BENEFITS 2007

Fairfax County Government Employees and Retirees

- Health/Vision Insurance
- Dental Insurance
- Deferred Compensation
- Flexible Spending Accounts
- Life Insurance
- Long Term Disability
- Long Term Care
- College Savings Plans

Employee Benefit Plans Summary Handbook

January 1, 2007 — December 31, 2007

Links for more information about your plan

BluePreferred PPO To see if your doctor is in the network http://www.bcbs.com/healthtravel/finder.html To see the cost of your prescription http://notesnet.carefirst.com/formulary/formulary.nsf To order a renewal prescription https://www.walgreensmail.com To see a list of mental health providers http://carefirst.com To see information on alternative therapies http://www.carefirst.com/pages/options/options.main.htm To contact customer service http://www.carefirst.com	**BlueChoice POS** To see if your doctor is in the network http://carefirst.com To see the cost of your prescription http://notesnet.carefirst.com/formulary/formulary.nsf To order a renewal prescription https://www.walgreensmail.com To see a list of dentists http://carefirst.com To see a list of mental health providers http://carefirst.com To see information on alternative therapies http://www.carefirst.com/pages/options/options.main.htm To contact customer service http://www.carefirst.com

Kaiser Permanente To select a doctor http://www.kaiserpermanente.org To see if a particular drug is in the formulary http://www.kaiserpermanente.org To order a renewal prescription http://www.kaiserpermanente.org To get answers to your health questions, http://www.kaiserpermanente.org To download a copy of the Signature Plan Member Guide http://www.kaiserpermanente.org To see a list of dentists through Kaiser's contracted dental plan http://www.kaiserpermanente.org To make a medical appointment http://www.kaiserpermanente.org To contact customer service http://www.kaiserpermanente.org	**CIGNA** To select a doctor http://CIGNA.benefitnation.net/CIGNA/docdir.html To see the cost of your prescription http://www.CIGNA.com For information on the mail-order prescription service http://www.CIGNA.com For information on the CIGNA Healthy Rewards program http://CIGNA.com/health/consumer/medical/discount.html

Delta Dental To select a dentist http://www.deltadentalva.com	**Davis Vision** http://www.davisvision.com
Deferred Compensation ICMA-RC http://www2.icmarc.org/xp/vl/ T Rowe Price http://www.rps.troweprice.com VALIC http://aigvalic.com/fairfaxcounty NATIONWIDE http://nationaldeferred.com	**Flexible Spending Account** Fringe Benefits Management Company (FBMC) http://myFBMC.com
Long-Term Care Insurance For information about the plan http://www.aetna.com/group/fairfaxcounty	**Virginia College Tuition Savings Plans** Virginia Prepaid Education Program http://www.virginia529.com Virginia Education Savings Trust http://www.virginia529.com College America http://www.americanfunds.com

Fairfax County Government employees enjoy a comprehensive benefits package during their career and into retirement.

In this benefits handbook we provide information on those benefits administered by the Employee Benefits Division of the Department of Human Resources, which include health, dental and vision insurance, deferred compensation, flexible spending accounts, group term life insurance, long-term disability (salary insurance), long-term care insurance and the Virginia College Savings Plan. In addition, we provide information on retiree health, dental, vision and life insurance benefits.

On average, County benefits increase the value of your compensation by 25% or more.

The *Fairfax County Government Employee Handbook*, also available from the Department of Human Resources, covers all other programs, including leave policies, child care services, the Employee Assistance Program, holidays, employee fitness, and pay rates.

Retirement plan benefits for County employees are outlined in the booklets for the various County retirement systems. These booklets are available at the Government Center in the Department of Human Resources, Suite 270; and from the Retirement Administration Agency office at 10680 Main Street, Suite 280, Fairfax City. All of these materials are also available on the Infoweb.

Every other week, the Department of Human Resources provides information on your benefits during new employee orientation. Current employees are welcome to attend to learn more about available benefits. Check the Human Resources site on the Infoweb for a schedule of orientation sessions.

Do you have a human resources question?
E-Mail your question to HRCentral@fairfaxcounty.gov.

The Human Resources website on the Infoweb also provides information on all benefits offered through the County that are included in this booklet. There are also direct links to the various County benefit providers, as well as enrollment forms that can be downloaded.

We are happy you have decided to make a career at Fairfax County and we are here to help you make the best decisions on your benefits, both for now and in the future. Come see us anytime.

Peter J. Schroth
Director, Department of Human Resources

New employees
New employees have 60 calendar days from their date of hire into a benefit-eligible position to enroll in benefit plans.

Current employees
Current employees can request changes to their benefits during open enrollment or within 60 days of a qualifying event.

Open enrollment
is Oct. 16 – Nov. 17, 2006, for employees and Oct. 23 – Nov. 17, 2006 for retirees. All open enrollment changes to health and dental insurance, as well as the flexible spending programs, are effective Jan. 1, 2007.

Requests to increase optional and dependent life insurance will require approval by Minnesota Life. (Employees can apply for long term care and long term disability at any time.)

Special Enrollment Opportunity for Long-Term Disability Insurance
CIGNA has removed the medical evidence of insurability requirement, allowing employees to enroll without proof of good health during this open enrollment period only.

What you will find in this booklet

If you are a new employee of Fairfax County government, or a current employee with benefit questions, this booklet will help you understand and make decisions on County benefits available to you and your family. It provides information on the County's health, dental and vision plan coverages, deferred compensation program, flexible spending account programs, the Virginia College Savings Plan, life insurance, disability insurance, and long-term care insurance.

In you are a new employee, you have 60 calendar days from your date of hire into a benefits-eligible position to enroll in the various benefit plans offered. The benefit plans subject to the 60-day deadline include health insurance, dental insurance, group term life insurance, long-term disability insurance, long-term care insurance and flexible spending accounts. You may enroll in the deferred compensation plan at any time. A separate 30-day deadline applies to the County's Employee Retirement System.

If you are a current employee, you are eligible to make changes to your health and dental plans, add or drop dependents, cancel your plan, enroll in flexible spending accounts for the next year, or request to increase or decrease your group term life insurance coverage and/or dependent coverage during the annual open enrollment period. This year, the open enrollment period will be Oct. 16 - Nov. 17, 2006, with changes effective Jan. 1, 2007.

If you are a retiree who retained health and/or dental coverage into retirement, you are eligible to make changes to your health and dental plans and add dependents to your plan during the open enrollment period. Remember, retirees can cancel coverage any time during the year, but once coverage is cancelled by the retiree, it is not possible to reenroll in a County plan in the future. Open enrollment for retirees is Oct. 23 – Nov. 17, 2006.

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Fairfax County is committed to nondiscrimination on the basis of disability in all county programs, services and activities. Reasonable accommodations will be provided upon request. For information, call

703-222-5872 (voice) or (703) 222-7314 (TTY) or (703) 802-8795 (FAX).

Your health, dental and vision benefits

Fairfax County offers its employees and retirees a variety of health plans from which to choose, and a comprehensive PPO dental plan.

Health plans for 2007 include: CIGNA Open Access Plus (OAP), BlueChoice Point of Service (POS), BluePreferred PPO, and Kaiser Permanente HMO. Vision benefits are provided as part of all health plans through Davis Vision. The dental plan offered is Delta Dental of Virginia PPO.

If you are currently enrolled in CIGNA, BlueChoice POS, BluePreferred PPO, Kaiser Permanente or Delta Dental and choose to continue with your current plan, you do **not** have to re-enroll during open enrollment. If you would like to change the health plan under which you are enrolled, drop coverage for yourself, enroll for dental coverage, or add or drop dependents, you must make this change during open enrollment. Open enrollment changes and cancellations can be made by the employee through BENELOGIC, the County's on-line enrollment provider. Go to Benelogic's website: www.fairfaxcountybenefits.benelogic.com to review and make changes to your benefit elections. For assistance in using the BENELOGIC website, review the Fairfax County Benefits Online brochure in the Benefits section of the County Infoweb. If you need more assistance, contact your agency payroll contact or call HR Central at 703-222-5872. You may also visit HR Central in Suite 270 of the Government Center. Changes will be effective Jan. 1, 2007.

Health plans

The next two sections contain general information about the health benefit plans offered by the County, and summarize the major features of each of the plans. Plan details are not covered in this summary: **Refer to the benefit booklets for the individual plans for specific information on plan benefits.**

You may enroll in one of the following health insurance plans:

- **CIGNA Open Access Plus (OAP):** This plan allows members to see any licensed provider they choose but their out-of-pocket cost is less if they see a provider in the Open Access Plus nationwide network. Members are encouraged (but not required) to see a primary care physician for routine care. No referrals are needed to see a specialist.

- **BlueChoice POS:** A point-of-service plan (POS) combining the best features of a health maintenance organization (HMO) and a traditional indemnity plan. Employees have access to the BlueChoice HMO network, which covers Northern Virginia, Maryland and Washington, D.C. Employees can also choose to use a non-HMO provider and use the indemnity portion of the plan.

- **BluePreferred PPO:** A preferred provider plan providing both in-network and out of network benefits. The in-network benefit allows for access to a nationwide network of doctors and other health providers, including hospitals,

Changes for this year include:

CIGNA Open Access Plus

- The CIGNA HMO plan has been replaced by the CIGNA Open Access Plus Plan.
- Existing CIGNA members will automatically be enrolled in this new plan and can take advantage of the nationwide network and the new benefit design.

Davis Vision

- An expanded vision benefit has been added using the Davis Vision network.
- The vision benefit is included with the health plan election.

BlueChoice POS and BluePreferred PPO

- All participants will receive new identification cards.

Kaiser Permanente

- Medicare Plus for retirees will continue to be closed for the present time; current Medicare Plus subscribers may remain in the group

who have agreed to discount their usual fees for plan members. When you use a provider in the network, the charges to the health insurance plan are lower, giving you the highest level of benefits. Employees can also choose to use a non-PPO provider and pay higher deductibles and copayments.

- **Kaiser Permanente:** A group model HMO**.** You receive medical care at one of the Kaiser Permanente facilities in the Washington metropolitan area, or at one of the local area hospitals authorized by Kaiser Permanente. Specialists may be located at the Kaiser facility or in private practice. Your physician must refer you for specialty care.

Refer to the individual plan booklets for plan specific benefit information. If there is a conflict between the eligibility rules in a health plan booklet and in this booklet, the County's rules in this booklet will apply.

It is a good idea to attend one of the County's employee meetings during open enrollment. Representatives from the Employee Benefits Division and the individual plans will be available at these meetings to answer your questions.

Features of the CIGNA Open Access Plus (OAP), BlueChoice POS and BluePreferred PPO plans

Flexibility

The CIGNA Open Access Plus (OAP) plan, the BlueChoice POS plan and the BluePreferred PPO plan are designed to offer you flexibility because each time you need care you can choose the option you want to use. The CIGNA Open Access Plus plan gives you the low cost option of choosing an in-network provider or primary care physician from its large nationwide network but you can see in-network specialists without a referral or see out-of-network providers at any time. The BlueChoice POS plan gives you a low cost option of choosing an in-network primary care physician from its BlueChoice HMO network, but you do need to obtain referrals to in-network specialists. You can see out-of-network providers at any time. The BluePreferred PPO plan offers you flexibility because you don't need to get referrals, you don't need to select a primary care physician (PCP), and it has a larger nationwide network.

Self-insured

The CIGNA Open Access Plus, the BlueChoice POS and the BluePreferred PPO plans are self-insured by the County. This means that your biweekly payroll health insurance deductions and the County's share of the premium are deposited into a trust fund set up by the County. Any interest accumulated in the trust fund is not paid to an insurance company, but is returned to the trust fund to reduce premium costs.

With a self-insured plan, the County, not a health plan, actually pays the cost of your health care claims. CIGNA or CareFirst will process claims from hospitals, doctors, and other health care providers. The County is then billed for these paid claims and must reimburse the health plans for these costs. The healthier participants are, the fewer claims the County must pay. This helps control the cost of health insurance for both plan members and the County.

Earn a Reward By Finding Billing Errors

CIGNA OAP, BlueChoice POS and BluePreferred PPO members who detect errors of more than $50 in their medical bills will receive a reward of half of the amount saved, up to $1,000.

For more information about the Duplicate Billing/Overpayment Award Program, call 703-324-3316.

Duplicate Billing/Overpayment Award Program

This program is designed to encourage employees to review their medical bills paid by the health plans. CIGNA Open Access Plus, BlueChoice POS or BluePreferred PPO subscribers who detect errors of more than $50 in their medical bills or their dependents' medical bills will receive a financial reward of half the amount saved, up to $1,000. The remaining savings will be returned to the trust fund and used to pay other claims. For more information, contact the Employee Benefits Division of the Department of Human Resources at 703-324-3316.

Vision plan

The Davis Vision plan offers a nationwide network of over 22,000 eyecare and eyewear providers, including independent optometrists and ophthalmologists and several well-known retail providers. A limited out-of-network benefit is also available.

All county employees, retirees and eligible dependents enrolled in County health coverage will automatically be enrolled in the Davis Vision plan with no additional premium. Your effective date of coverage is the same as for your health insurance benefit.

How to Locate a Network Provider

You can search for a network provider on the Davis Vision website at www.davisvision.com. You may also call 800-208-2112 to access Davis Vision's interactive voice response unit which will supply you with the names and locations of the network providers nearest you.

How to Use the Program

To use the program:

- Call the network provider of your choice,
- Identify yourself as a Davis Vision plan participant and a Fairfax County Government employee, retiree or dependent,
- Provide the office with the ID number located on your ID card and the name and date of birth of any covered individual needing services,
- Schedule an appointment.

You may receive your eye examination and eyeglasses (or contact lenses) on different dates or through different provider locations. However, complete eyeglasses must be obtained at one time, from one provider. Continuity of care will best be maintained when all available services are obtained at one time from one provider.

Davis Vision Plan Offers:

- Over 22,000 network providers.
- Choice of eyeglasses or contact lenses.
- Discounts on laser vision correction services at participating providers.

Who to contact

Davis Vision
(800) 208-2112
www.davisvision.com

County Benefits
703-324-4916

Things to note

Vision benefits are provided to all County employees, retirees and dependents enrolled in County health coverage with no additional premium.

Who to contact

Before choosing a health plan, read the material carefully to make sure it will meet your particular needs.

CIGNA OAP
(800) 244-6224
www.cigna.com

County Benefits
703-324-4916

CareFirst BlueChoice POS
(800) 296-0724
www.carefirst.com

County Benefits
703-324-4708

CareFirst BluePreferred PPO
(800) 296-0724
www.bcbs.com

County Benefits
703-324-4708

CareFirst Help Desk
Betsi Fuhrman
703-324-3474

Kaiser Permanente
(301) 468-6000
www.kaiserpermanente.org

County Benefits
703-324-4916

Davis Vision
(800) 208-2112
www.davisvision.com

County Benefits
703-324-4916

Your eyewear will be delivered to your provider from the laboratory generally within 2 to 5 business days. More delivery time may be needed when out-of-stock frames, anti-reflective coating, specialized prescriptions or a participating provider's frame is selected.

The Davis Vision plan also offers:

- Laser vision correction services at discounts of up to 25% off a participating provider's normal charges, or 5% off any advertised special,
- Free membership and access to a mail order replacement contact lens service (Lens 123), and
- A one-year unconditional breakage warranty for all eyeglasses completely supplied through the Davis Vision collection.

Exclusions and limitations

The following items are not covered by the Davis Vision plan:

- Medical treatment of eye disease or injury.
- Vision therapy.
- Special lens designs or coatings, other than those described in the Vision Benefits at a Glance chart.
- Replacement of lost eyewear.
- Non-prescription (plano) lenses.
- Contact lenses and eyeglasses in the same benefit cycle.
- Services not performed by licensed personnel.
- Two pairs of eyeglasses in lieu of a bifocal.

Claims filing

If you use a network provider, you will not be required to file any claim forms.

If you receive services from an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for partial reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Only one claim per service may be submitted for reimbursement each benefit cycle. Claim forms can be obtained from the Davis Vision website at www.davisvision.com or by calling 1-800-208-2112.

Things to consider when choosing a health plan

1. Do you need County health insurance?

If you have no other health insurance the answer almost certainly is YES. But if you are now covered by your spouse's plan, have a Medigap supplement, or are covered under a federal plan or another retiree plan, then you may not need a second plan. You do not want to pay for two plans that offer duplicate benefits, but make a well-informed decision before dropping any plan you have now. You may not be able to reinstate your coverage at a later time.

2. Consider your overall health, frequency of illness, and any special needs you or your family may have.

Are you looking for insurance just to cover an unexpected accident or major illness, or do you have a recurring need for treatment? Be sure the plan you select will cover any special condition that is of concern to you. Many plans have exclusions. There may be other restrictions. Read the plan literature carefully and call the Member Services Department of the health plan if you have unanswered questions.

3. Is it convenient?

Do you want to avoid filling out claim forms and paying some costs in advance of reimbursement? If you choose an HMO, how convenient is its closest center or participating doctor's office to your home or office? Are the appointment hours convenient? Which hospitals participate in the plan?

4. How much will it cost?

Be sure to look at both the biweekly premium deduction from your paycheck and out-of-pocket expenses, such as co-payments and deductibles.

5. Does it cover newborn costs?

If you are enrolled in a health plan and your spouse is covered under another health plan, you should review the rules regarding coverage for a healthy newborn baby.

Remember, you must add your newborn within 60 days from date of birth, in order for the baby’s expenses to be covered by the health plan.

Fairfax County Government
Health, Vision and Dental Insurance Premiums for Employees
January 1, 2007- December 31, 2007

	Total Premium Cost	County Share	Employee Monthly Share	Employee Biweekly Share
BlueChoice POS + Davis Vision				
Individual	$ 452.20	$384.38	$ 67.82	$ 33.91
2 Party	$ 888.66	$666.50	$222.16	$111.08
Family	$1,306.94	$980.20	$326.74	$163.37
BluePreferred PPO + Davis Vision				
Individual	$ 520.02	$ 442.02	$ 78.00	$ 39.00
2 Party	$ 1,021.96	$ 766.48	$255.48	$127.74
Family	$1,503.00	$1,127.26	$375.74	$187.87
Kaiser HMO + Davis Vision				
Individual	$ 349.26	$ 296.88	$ 52.38	$ 26.19
2 Party	$ 680.49	$ 510.37	$170.12	$ 85.06
Family	$1,012.58	$ 759.44	$253.14	$126.57
CIGNA OAP + Davis Vision				
Individual	$ 358.62	$304.84	$ 53.78	$ 26.89
2 Party	$ 699.34	$524.50	$174.84	$ 87.42
Family	$1,043.58	$782.68	$260.90	$130.45
Delta Dental				
Individual	$ 32.24	$ 16.12	$ 16.12	$ 8.06
2 Party	$ 60.88	$ 30.44	$ 30.44	$ 15.22
Family	$ 100.32	$ 50.16	$ 50.16	$ 25.08

HEALTH CARE BENEFITS AT-A-GLANCE

CIGNA OPEN ACCESS PLUS (OAP)		
	In-Network	**Out-of-Network**
Annual Deductible	None	$250 individual/$500 family For family coverage, all covered family members' allowable expenses are combined to reach the deductible.
Yearly Out-of-Pocket Limit	None	$2,500 individual/$5,000 family (does not include deductible). For family coverage, all covered family members' allowable expenses are combined to reach the out-of-pocket maximum.
Lifetime Maximum Benefits	None	$1,000,000 per person in covered major medical benefits.
Office Visits, Physical Exams and Routine Immunizations	Covered in full after $10 co-pay.	Covered at 70% of plan allowance after deductible.*
Inpatient Hospital Care	Covered in full.	Covered at 70% of plan allowance after deductible.*
In Hospital Doctors' Services	Covered in full.	Covered at 70% of plan allowance after deductible.*
Infertility Coverage	Covers testing and treatment for underlying medical condition, diagnosis, medical/surgical treatment to restore fertility and artificial insemination. $10 co-pay for office visit; $25 co-pay for facility visit. Excludes drugs, in-vitro, GIFT, ZIFT, etc.	Covered at 70% of plan allowance after deductible.* Covers testing and treatment for underlying medical condition, diagnosis, medical/surgical treatment to restore fertility and artificial insemination. Excludes drugs, in-vitro, GIFT, ZIFT, etc.
Maternity Care	Covered in full after $10 co-pay for initial visit to confirm pregnancy.	Covered at 70% of plan allowance after deductible.*
Well Child Care	Covered in full after $10 co-pay.	Well child visits under age 18, including immunizations, are covered at 70% of plan allowance not subject to deductible.*
Mental Health Services and Substance Abuse Treatment	**Inpatient –** Covered in full for up to 30 days combined mental health and substance abuse maximum per calendar year;* 90 day lifetime maximum for substance abuse only. **Outpatient –** Covered in full after following per-visit co-pays: Visits 1-5: $10 co-pay Visits 6-30: $20 co-pay Visits 31+: $25 co-pay	**Inpatient –** Covered at 70% of plan allowance after deductible,* for up to 30 days mental health and substance abuse maximum per calendar year,* 90 day lifetime maximum for substance abuse only. **Outpatient –** Covered at 70% of plan allowance after deductible.*
Prescription Drugs	*Retail* (up to 30 day supply): $10 – co-pay for generic drugs $20 – co-pay for formulary brand name drugs $40 – co-pay for non-formulary brand name drugs. *Mail order* (up to 90 day supply): $20 – co-pay for generic drugs $40 – co-pay for formulary brand name drugs $80 – co-pay for non-formulary brand name drugs.	Covered at 70% of plan allowance for prescriptions received at non-participating pharmacies. No out-of-network coverage for mail order.
Laboratory & X-ray	Covered in full at physician's office after $10 office visit co-pay. Covered in full at radiology and lab centers or outpatient department of hospital.	Covered at 70% of plan allowance after deductible.*
Routine Vision Care	Vision benefits provided by Davis Vision.	Vision benefits provided by Davis Vision.
Outpatient Short-Term Therapies, Cardiac Rehab, Chiropractic Care	Covered in full after $20 co-pay, up to 90 days combined for all in-network and out-of-network therapy, rehab and chiropractic care per calendar year.	Covered at 70% of plan allowance after deductible, up to 90 days combined for all in-network and out-of-network therapy, rehab and chiropractic care per calendar year.*
Emergency Treatment	Covered in full after $50 co-pay for emergency services. (Waived if admitted.)	Benefits provided in-network for a true emergency. Otherwise, covered at 70% of plan allowance after deductible.*

* After maximum out-of-pocket amount is reached, plan pays at 100% of plan allowance.

HEALTH CARE BENEFITS AT-A-GLANCE

BLUECHOICE POS		
	In-Network	**Out-of-Network**
Annual Deductible	None	$250 per person/$500 family For family coverage, once two family members meet the deductible, the entire family has met the deductible for the remainder of the year.
Yearly Out-of-Pocket Limit	None	$2,500 per person/$5,000 family (does not include deductible). Once two family members meet the out-of-pocket limit, the entire family has met the out of pocket limit for the remainder of the year.
Lifetime Maximum Benefits	None	$1,000,000 per person in covered major medical benefits.**
Office Visits, Physical Exams and Routine Immunizations	Covered in full after $10 co-pay.	Covered at 70% of plan allowance after deductible.* Physical exams limited to one per calendar year.
Inpatient Hospital Care	Covered in full.	Covered at 70% of plan allowance after deductible.*
In Hospital Doctors' Services	Covered in full.	Covered at 70% of plan allowance after deductible.*
Infertility Coverage	Coverage for infertility services for in-vitro fertilization for up to 3 completed attempts per lifetime. $100,000 lifetime maximum.**	Covered at 70% of plan allowance after deductible* for in-vitro fertilization for up to 3 completed attempts per lifetime. $100,000 lifetime maximum.**
Maternity Care	Covered in full after $10 co-pay.	Covered at 70% of plan allowance after deductible.*
Well Child Care	Covered in full after $10 co-pay.	Well child visits under age 18, including immunizations, are covered at 70% of plan allowance not subject to deductible.*
Mental Health Services and Substance Abuse Treatment	**Inpatient –** Covered in full for up to 30 days combined mental health and substance abuse maximum per calendar year; 90 day lifetime maximum for substance abuse only. (Physician covered in full after $25 co-pay for one visit per day up to 30 days per calendar year.) **Outpatient –** Covered in full after $25 per visit co-pay.	**Inpatient –** Covered at 70% of plan allowance after deductible,* up to 30 days combined mental health and substance abuse maximum per calendar year; 90 day lifetime maximum for substance abuse only. **Outpatient –** Covered at 70% of plan allowance after deductible*.
Prescription Drugs	*Retail* (up to 34 day supply): $10 – co-pay for generic drugs $20 – co-pay for formulary brand name drugs $35 – co-pay for non-formulary brand name drugs. *Mail order* (up to 90 day supply): $20 – co-pay for generic drugs $40 – co-pay for formulary brand name drugs $70 – co-pay for non-formulary brand name drugs.	Same as In-Network.
Laboratory & X-ray	Covered in full at approved radiology and laboratory centers, $25 co-pay at approved outpatient department of hospital.	Covered at 70% of plan allowance after deductible.*
Routine Vision Care	Vision benefits provided through Davis Vision.	Vision benefits provided through Davis Vision.
Dental Care	Discounts on services provided by participating dentists.	Routine care not covered.
Physical Therapy	Covered in full after $10 co-pay, up to 90 days per condition per calendar year.	Covered at 70% of plan allowance after deductible.*
Emergency Treatment	Covered in full after $50 co-pay for a bona fide accidental injury or medical emergency. (Waived if admitted.) Otherwise benefit will be provided out-of-network.	Benefits provided in-network for a bona fide accidental injury or medical emergency. Otherwise, covered at 70% of plan allowance after deductible.*

* After maximum out-of-pocket amount is reached, plan pays at 100% of plan allowance. **BlueChoice POS and BluePreferred PPO combined.

HEALTH CARE BENEFITS AT-A-GLANCE

BLUEPREFERRED PPO		
	In-Network	**Out-of-Network**
Annual Deductible	None	$250 per person/$500 family For family coverage, once two family members meet the deductible, the entire family has met the deductible for the remainder of the year.
Yearly Out-of-Pocket Limit	$1,000 per person (does not include deductible or co-payments). Two family members must meet out-of-pocket limit.	$2,500 per person/$5,000 family (does not include deductible). Once two family members meet the out-of-pocket limit, the entire family has met the out of pocket limit for the remainder of the year.
Lifetime Maximum Benefits	None	$1,000,000 per person in covered major medical benefits.**
Office Visits, Physical Exams and Routine Immunizations	Covered in full after $10 co-pay.	Covered at 70% of plan allowance after deductible.* Physical exams limited to one per calendar year.
Inpatient Hospital Care	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Inpatient Physician Billed Services	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Infertility Coverage	Coverage for infertility services for in-vitro fertilization for up to 3 completed attempts per lifetime covered at 90% of plan allowance.* $100,000 lifetime maximum.**	Covered at 70% of plan allowance after deductible* for in-vitro fertilization for up to 3 completed attempts per lifetime. $100,000 lifetime maximum.**
Maternity Care	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Well Child Care	Covered in full after $10 co-pay.	Well child visits under age 18, including immunizations, are covered at 70% of plan allowance not subject to deductible.*
Mental Health Services and Substance Abuse Treatment	**Inpatient –** Covered in full for up to 30 days combined mental health and substance abuse maximum per calendar year; 90 day lifetime maximum for substance abuse only. (Physician covered in full after $25 co-pay for one visit per day up to 30 days per calendar year.) **Outpatient –** Covered in full after $25 per visit co-pay.	**Inpatient –** Covered at 70% of plan allowance after deductible,* up to 30 days combined mental health and substance abuse maximum per calendar year; 90 day lifetime maximum for substance abuse only. **Outpatient –** Covered at 70% of plan allowance after deductible.*
Prescription Drugs	*Retail* (up to 34 day supply): $10 – co-pay for generic drugs $20 – co-pay for formulary brand name drugs $35 – co-pay for non-formulary brand name drugs. *Mail order* (up to 90 day supply): $20 – co-pay for generic drugs $40 – co-pay for formulary brand name drugs $70 – co-pay for non-formulary brand name drugs.	Same as In-Network.
Laboratory & X-ray	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Routine Vision Care	Vision benefits provided through Davis Vision.	Vision benefits provided through Davis Vision.
Dental Care	N/A	N/A
Physical Therapy	Covered at 90% of plan allowance*, up to 90 days per condition per calendar year.	Covered at 70% of plan allowance* after deductible.
Emergency Treatment	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*

* After maximum out-of-pocket amount is reached, plan pays at 100% of plan allowance. **BlueChoice POS and BluePreferred PPO combined

HEALTH CARE BENEFITS AT-A-GLANCE

	KAISER HMO
Annual Deductible	None
Yearly Out-of-Pocket Limit	N/A
Lifetime Maximum Benefits	None
Office Visits, Physical Exams and Routine Immunizations	Covered in full after $10 co-pay; $0 co-pay for children up to 5 years of age.
Inpatient Hospital Care	Covered in full.
In Hospital Doctors' Services	Covered in full.
Infertility Coverage	Coverage for infertility services for in-vitro fertilization for up to 3 completed attempts per lifetime; covered at 50% of allowable charges.
Maternity Care	Covered in full after a $10 co-pay on the first prenatal visit.
Well Baby Care	Covered in full; $0 co-pay up to 5 years of age; $10 co-pay per visit thereafter.
Mental Health Services	**Inpatient –** Covered in full when medically necessary. **Outpatient -** $10 co-pay per visit when medically necessary.
Alcohol and Drug Abuse Treatment	Same as mental health.
Prescription Drugs	Kaiser pharmacy (up to 30 day supply): $10 co-pay for generic drugs $20 co-pay for brand formulary $35 co-pay for non-formulary Community pharmacy (up to 30 day supply): $20 co-pay generic $40 co-pay brand formulary $55 co-pay non-formulary Mail order (up to 90 day supply): $16 co-pay generic $36 co-pay brand formulary $66 co-pay non-formulary
Laboratory & X-ray	Covered in full.
Vision Care (provided in addition to Davis Vision Plan)	Covered in full after $10 co-pay for optometry (eye refraction exam only) and ophthalmology visits; 25% eyeware discount; 15% initial fitting and contact lens discount.
Dental Care	Discounts on services.
Physical Therapy	Short-term therapy covered in full after $10 co-pay per visit. 90 day limit per incident per contract year.
Emergency Treatment	Covered in full after $50 co-pay per visit. Waived if admitted.

VISION BENEFITS AT-A-GLANCE

DAVIS VISION PLAN		
	In-Network	**Out-of-Network**
ROUTINE EYE EXAMINATION (Once every 12 months):	Covered in full after $15 co-pay. Eye examination with dilation, as professionally indicated, included.	Covered up to $40.
FRAMES (Once every 24 months in lieu of contact lenses):	Davis Vision Designer Collection (available at independent network providers): Covered in full Davis Vision Premier Collection (available at independent network providers): $25 co-pay. Outside Davis Vision Collection (available at all independent and retail network providers): $100 allowance	Covered up to $50.
SPECTACLE LENSES (Once every 12 months in lieu of contact lenses):		
Single Vision	Covered in full.	Covered up to $50.
Bifocal Lenses	Covered in full.	Covered up to $75
Trifocal Lenses	Covered in full.	Covered up to $100.
Lenticular Lenses	Covered in full.	Covered up to $150.
Scratch Resistant Coating	Covered in full.	Included in base lens reimbursements above.
Other Lens Options	Available at discounted fixed fees.	Not covered.
CONTACT LENSES (Once every 12 months in lieu of eyeglasses):		
Contact Lens Materials	1 pair of standard, soft daily wear; 2 boxes of planned replacement; or 4 boxes of disposables covered in full if from Davis Vision Formulary (available at independent network providers). Elective contact lenses outside of Davis Vision Formulary (available at all independent and retail network providers): $100 allowance	Covered up to $100.
Contact Lens Fitting Fee with 2 Follow Up Visits	Covered in full after $20 co-pay.	Covered up to $40.
Medically Necessary Contact Lenses (with prior approval)	Covered in full.	Covered up to $225.
ADDITIONAL FEATURES:		
One-Year Eyeglass Breakage Warranty	Included for all spectacle lenses, Davis Vision Collection frames and retailer supplied frames.	Not included.
Lens 1-2-3!® Membership	Included.	N/A
Laser Vision Correction Discount	Up to 25% off the provider's usual and customary fees, or a 5% discount on any advertised special.	Not covered.
Low Vision Coverage	Included.	Not included.

Dental plan

The Delta Dental Plan of Virginia PPO uses preferred provider national networks as well as an out-of-network option.

To use the program, just call the dental office of your choice and make an appointment. You may change dentists at any time without preapproval and you may elect to go to a specialist without preapproval. Your level of benefits and out-of-pocket costs will depend on whether the dentist you choose is in the Delta Dental Premier network, the Delta Dental PPO network, or is an out-of-network dentist. The highest level of benefits and the lowest out-of-pocket costs are generally available from a Delta Dental PPO dentist. It is recommended, but not required, that for services over $250, that a pre-determination be filed on your behalf so that you will be aware of your financial responsibility in order to avoid unexpected charges.

A complete list of Delta Dental PPO and Delta Dental Premier dentists is available on the website at www.deltadentalva.com. You may also call 800-237-6060.

During your first appointment, provide your dentist with the following information:

- the subscriber's identification number which is usually the subscriber's social security number
- inform the dentist that your program is through Delta Dental Plan of Virginia.

Delta Dental PPO – 3 types of dental plans in one:

Delta PPO– highest level of benefit

Delta Premier – largest network

Out-of-Network – any licensed dentist

Effective date

For new hires, coverage will be effective the first of the calendar month following your request for enrollment. For qualifying events, see pages 38-41. For open enrollment, coverage will be effective the first of the calendar year.

Exclusions and limitations

See plan brochure for a complete list of exclusions and limitations.

Who to contact

Delta Dental Plan of Virginia PPO
(800) 237-6060
www.deltadentalva.com

County Benefits
703-324-4708

Claims filing

Participating Delta Dental dentists agree to:

- Complete the dentist's portion of the claim form at no extra charge and submit the claim directly to Delta Dental Plan of Virginia.
- Accept Delta Dental's payment and any patient co-insurance as payment in full for covered benefits.
- Participate in Delta Dental's quality assurance programs.

Many out-of-network dentists will typically file the claim form for you. Delta will accept any standard ADA approved claim form. Forms are available online at www.deltadentalva.com or by calling Delta Dental at 800-237-6060. The claim forms should be mailed to Delta Dental Plan of Virginia, 4818 Starkey Road, S.W., Roanoke, VA 24014.

Things to note
The County makes a 50% contribution to dental premiums for active

Premiums

The County pays 50% of the dental premiums. Premiums are deducted pre-tax, biweekly, in the month of coverage. The biweekly payroll deductions for the period January 1, 2007 through December 31, 2007 are noted on page 6.

DELTA DENTAL PLAN
Comparison of Employee Out-of-Pocket Costs and Plan Design

Coverage	Plan Pays			Benefit Limitations
	In Network Preferred PPO	In Network Premier	Out of Network	
Diagnostic and Preventive	**100%**	**100%**	**80%**	**These services are exempt from the deductible**
-- Oral exams and cleanings				Twice each calendar year
-- Fluoride treatment				Once each calendar year for dependents under age 19
-- Bitewing x-rays				Once each calendar year, limited to posterior teeth
-- Full mouth or panelipse x-rays				Once each three years
-- Space maintainers				For dependents under age 14
-- Sealants				Only for non-carious, non restored 1st and 2nd permanent molars for dependent children under age 16, limited to one application per tooth
Basic Dental Care	**90%**	**80%**	**80%**	**(Deductible Applies)**
-- Amalgam (silver) and composite (white) fillings				Composite fillings limited to the upper and lower 6 front teeth
-- Stainless steel crowns				Limited to baby/primary teeth for patients under age 13
-- Oral surgery				Simple extractions
-- Denture repair and recementation of existing crowns, bridges and dentures				Cost limited to ½ the cost of a new denture or prosthesis
Other Basic Dental Care	**60%**	**50%**	**50%**	**(Deductible Applies)**
-- Oral surgery				Impactions and other surgical procedures
-- Endodontics (root canal therapy)				Repeat treatment is a covered benefit only after 2 years from initial treatment
-- Periodontics (scaling and root planing, soft tissue and bony surgery, including grafts)				Limitation of 2-3 years apply based on services rendered; periodontic cleaning is considered a regular cleaning and is subject to the benefits limitations for regular cleanings
Major Dental Care	**60%**	**50%**	**50%**	**(Deductible applies)**
--Crowns (single crowns)				Once per tooth every 5 years, and only when existing crown cannot be rendered serviceable; benefit available only if the tooth is damaged by decay or fractured to the point it cannot be restored by an amalgam or composite restoration; crowns for dependents under the age of 12 are not covered.
--Prosthodontics (partial or complete dentures and fixed bridges)				Once every 5 years, and only when an existing prosthesis cannot be rendered serviceable; fixed bridges or removable partials are not benefits for dependents under age 16
Orthodontic Benefits -- Removable fixed appliance therapy and comprehensive therapy	**50%**	**50%**	**35%**	**(Deductible Applies)** For dependent children to age 19
Lifetime Orthodontic Maximum	**$2,000**			
Calendar Year Deductible	**$50**			Limit of 3 per family
Annual Benefit Maximum	**$2,000**			Per member

How to enroll in a health or dental plan

- New employees and employees who are newly eligible for benefits have 60 calendar days to make their elections for health and/or dental coverage (see deadline chart on pages 74-76).

- Current employees electing to make benefit changes during open enrollment must complete their enrollment no later than midnight, Nov. 17, 2006. Complete your enrollment on-line through the BENELOGIC website: www.fairfaxcountybenefits.benelogic.com
- Review the benefits offered by each plan.
- Determine which plan best meets your needs.
- If you are requesting coverage for your spouse, submit a copy of your marriage certificate or last year's income tax form showing that you are married (if documents are not already on file with the Dept. of Human Resources).
- If adding a dependent child, submit a copy of the birth certificate for the child (if documents are not already on file with the Dept. of Human Resources). For newborns, you may submit a copy of the proof of birth letter from the hospital instead of the birth certificate.
    - For children, age 19 but less than 23, you will need to verify that they are full-time students. You will be asked to submit a student status verification form to be completed by your child's school.
- Return the required documentation to the Employee Benefits Division of the Department of Human Resources by the designated deadline. If you miss the deadline, you must wait until the next open enrollment period unless you have one of the qualifying changes in status events. See pages 38-41.
- If required documentation is not received by the deadline specified, your enrollment cannot be processed.
- If you enroll in a health or dental plan, you are authorizing the County to take pre-tax deductions from your pay for the biweekly premium amount.
- If you are canceling health or dental insurance coverage during open enrollment, be sure to make your cancellation online through the BENELOGIC website: www.fairfaxcountybenefits.benelogic.com .

Things to note

✓Any required documentation must be sent to the Employee Benefits Division of the Department of Human Resources by the designated deadline.

✓Enrollments submitted after your deadline will not be processed.

✓If you miss the deadline, you must wait until the next open enrollment period unless you have one of the qualifying change in status events. See pages 38-41.

Q&A: health, vision and dental plans

Q: Who is eligible for health and dental benefits?
All merit system employees of Fairfax County government (full and part-time) are eligible. Employees from other approved participating political subdivisions for which the Department of Human Resources administers benefits are eligible for some health benefits only. Exempt part-time (less than 20-hour non-merit) employees and exempt limited term employees are not eligible. To find out if you are eligible, ask your agency personnel or payroll contact.

Q: Are there any preexisting conditions that would prevent me from getting coverage?
No preexisting condition clauses preclude employees from receiving covered services in any Fairfax County-sponsored health insurance plan. There are several preexisting condition clauses in the dental insurance plan.

Q: How do I sign up for health or dental benefits?
You are responsible for signing up. Don't miss the deadline. Newly eligible employees have 60 calendar days from date of hire into a benefit eligible position to enroll. Enrollment is done on-line through Benelogic at www.fairfaxcountybenefits.benelogic.com or by completing a benefits Enrollment/Change Worksheet and returning it to the Employee Benefits Division of the Department of Human Resources. Your Enrollment/Change Worksheet must be received by the 60th calendar day of employment (see deadline calendar on pages 74-76). It is the employee's responsibility to ensure that they adhere to the deadline: do not rely on your agency to submit your form. Employees who do not meet this deadline may not enroll until the next open enrollment period unless there is a qualifying change in status event (see pages 38-41).

Your payroll contact can provide you with a packet of health and dental plan information. Additional information is provided at new employee orientation and on the Benefits website on the Infoweb.

Q: What is open enrollment?
Each fall, all benefit eligible employees are allowed to enroll, cancel their enrollment, or change their coverage during open enrollment. **This year's fall open enrollment period is Oct. 16 through Nov. 17, 2006.**

Benefit elections are binding for the plan year. **Cancellations or changes are not permitted** during the year unless you have a qualifying change in status event. Qualifying change in status events are explained on pages 38-41.

Employees who are enrolled in a County health or dental plan are not required to reenroll to maintain their same level of coverage. **There are different premiums for each of the plans. If you would like to be in a different plan from the one in which you are currently enrolled, you will need to make your elections on-line at www.fairfaxcountybenefits.benelogic.com for the new plan during open enrollment.**

You may change your primary care provider at any time, provided the new physician is within your current network and is accepting new patients. Effective dates for provider changes vary by plan. To change your primary care provider, call the plan's customer service number.

Q: What if I or my dependents move outside of the service area?
If you are enrolled in the BlueChoice POS or Kaiser Permanente plans and move outside of your designated network's service area, you may change to the CIGNA Open Access Plan or the BluePreferred PPO or cancel coverage within 60 days of your move. Retirees must change to a plan within their network service area. See pages 38-41 for required documentation.

Q: When do enrollments or changes become effective?

For new employees or mid year changes due to qualifying events, the effective date for health and dental insurance enrollments is the first day of the calendar month following the date in which your enrollment is received. The request may not be submitted prior to your hire date. However, it may take two to three weeks after your submission before you receive identification cards from the health and/or dental plan. (For qualifying events, see pages 38-41.)

Example: Newly eligible employee completes on-line enrollment or submits benefits enrollment any day in the month of July. The coverage will be effective Aug. 1.

Open enrollment changes are effective Jan. 1, 2007.

Q: What if I have to make a change outside of the open enrollment period?

The rules determining the effective dates for coverage type changes (i.e., adding or dropping dependents), and enrollment requests received after the initial eligibility period are described in the Changes in Status Events Chart on pages 38-41. Enrollment/change requests must be made within 60 calendar days of the qualifying event. See pages 74-76 for specific deadline dates. The enrollment/change request must be consistent with the qualifying event. For example, if you have a baby, it is not consistent with your qualifying event to drop coverage for other dependents.

Things to note about coverage changes

- When making changes to your coverage (for example, adding a new baby, dropping a dependent who is no longer eligible), submit a benefits Enrollment/Change Worksheet to the Benefits Division of the Department of Human Resources at Suite 270 of the Government Center (or fax to 703-802-8795).

- Whenever the rules allow you 60 calendar days to make your election, the election must be received within 60 days of the qualifying event. The first day of the qualifying event counts as day one. (See chart on pages 74-76.)

- Requests for change in coverage may not be submitted in advance. Wait until the event (e.g., birth or marriage) has actually occurred, and then make your election promptly. See pages 74-76 for specific deadline dates.

Q: What is the plan year?

The plan year is the calendar year.

Q: What if I leave my position with the County?

If you terminate or retire from County employment or move to a position that is not eligible for benefits, plan coverage ceases at the end of the month in which you terminate employment or in which your eligibility ends. Your termination date or change of status date is your last day of work or paid leave in a merit position. Once this coverage has terminated, eligible former employees may enroll in COBRA continuation coverage (see page 20) or the retiree health and/or dental plan (if eligible).

Q: Which coverage should I pick?

The County offers you three levels of coverage: individual (employee only); 2 party (employee and either spouse or eligible dependent child); and family (employee and two or more eligible dependents).

Spouse
You must be legally married to cover your spouse under the County's health and dental plans. If you are requesting coverage for your spouse, you must submit a copy of your marriage certificate or your most recent tax form showing that you filed "married." (See page 15 for required documentation and eligibility period.) When both husband and wife are County employees, each may enroll only once, either through his/her own enrollment or as a dependent. Double coverage is not allowed.

Dependents
An *eligible dependent child* is defined as any biological child, stepchild, adopted child, (or child placed for adoption), or child for whom the employee has been appointed by the court as legal guardian, or child for whom the employee has been granted permanent legal custody by the court who is:

- Unmarried;
- Under the age of 19; or
- Age 19 but less than 23, and a full-time student (as defined by the accredited college, university, vocational or technical school).

Disabled dependents, regardless of age, are eligible to remain on the County's health plans if the disability occurred before age 23, and the child meets the criteria established by the health insurance carrier.

Q: If the County receives a health insurance order from a child support enforcement agency or the court system, is the County required to enroll dependents in a health plan?

The County is required to enroll any qualified dependent(s) listed on a valid health insurance order into the named employee's County-sponsored health plan. If the employee is not enrolled in a plan, the County will give the employee the opportunity to choose a health plan. If the employee does not enroll the dependent(s) in a plan within the stipulated time frame, the County will enroll the employee and named dependent(s) into the least costly plan offered by the County.

Q: Who pays for employee health benefits?

Both employees and the County share in the cost of health coverage. The amount of the premium depends on your status (active or retired), the number of dependents (if any) covered, and the specific plan you choose. The County pays most of the health insurance premium for active employees (85 percent of the cost for individual coverage and 75 percent of the cost for 2 party or family coverage). You pay your share of the premium through pre-tax salary deductions. This means you get a tax break because your share of the health care premium is deducted from your pay before income taxes, Social Security and Medicare are calculated. See chart on page 6 for the payroll deduction amounts.

Premiums are deducted pre-tax, biweekly, in the month of coverage. For example: if an employee's coverage becomes effective Jan. 1, the employee's share of January's premium will be taken on the first two pay dates in January. Extra deductions may be necessary to cover missed deductions.

Q: What are pre-tax and tax-deferred benefits?

Premiums for health insurance, dental insurance, group term life insurance (the first $50,000 of coverage) and flexible spending accounts are deducted on a pre-tax basis. This means that the payroll deductions are not included in your taxable income, and no federal, state or Social Security (FICA) taxes are withheld on those deductions.

Tax-deferred deductions (i.e. for retirement and deferred compensation) also are not included in your taxable income. Federal and state taxes are not withheld on these deductions, however, FICA taxes will apply. Additionally, you will pay income taxes when you receive payments from those accounts.

Q: What dental benefits does the County offer?

There are several options for dental coverage. Limited dental coverage is offered through the Kaiser HMO and BlueChoice POS plans. This dental coverage is included with the health plans, and subscribers are automatically eligible for dental benefits when they enroll in these health plans. There is no dental program with the BluePreferred PPO plan or the CIGNA OAP plan.

Employees who need more comprehensive dental coverage may choose to enroll in the Delta Dental PPO plan. The County pays 50% of the dental premium for this coverage. See pages 12-14 for more information on this dental plan. You do not need to be enrolled in a health insurance plan in order to enroll in the Delta Dental PPO.

Q: What benefits are available while on Family and Medical Leave?

Under the Family and Medical Leave Act (FMLA), you may be eligible to take up to 12 weeks of leave annually following the birth or adoption of a child, to care for a child, spouse or parent who has a serious health condition, or when a serious health condition prevents you from working. During approved FMLA leave, you and the County may continue to make regular contributions for your health, dental and life insurance premiums or you may revoke an existing election of group health plan coverage and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA. (See the Qualifying Change in Status Events chart on pages 38-41.)

If an employee on Family and Medical Leave fails to return to work prior to termination of employment, the employee may be required to reimburse the County share of the health, dental and life premium paid on his or her behalf during the Family and Medical Leave period.

Q: Can I continue my benefits when I'm on Leave Without Pay (LWOP)?

Other than circumstances of approved FMLA Leave, in order for the County to pay the employer's share of your premium, you must be in a paid status (either working or on paid leave) for at least 40 hours (56 paid hours for firefighters on a 56-hour work schedule, 42 paid hours for 42-hour pay employees) in one of the two paydates in a calendar month.You will be sent a bill for the premium amount owed (County share plus employee share) with a date by which your payment must be received. If you do not make these payments within the time specified, you will be cancelled from the plan(s).

Employees who cancel coverage while on leave without pay (LWOP) may make a new election upon returning to work. A request for the new election must be made in writing and received by the Employee Benefits Division within 60 days of your return to a paid status for a minimum of 20 hours per week. Coverage will begin the first day of the calendar month following receipt of the enrollment form. COBRA continuation coverage is also available for employees and/or their dependents once coverage has been terminated under the County's plans (see page 20).

Benefits under the law

COBRA

What is continuation coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that most group health plans (including the County's health plan) give employees and their families the opportunity to continue their coverage when there is a "qualifying event" that would result in a loss of coverage under the employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and the covered dependent children of the covered employee.

Continuation coverage is the same coverage that the County's health plan gives to other participants or beneficiaries who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the County's plan as other covered participants or beneficiaries, including open enrollment and special enrollment rights.

COBRA questions?

Contact the COBRA administrator at:

Benefits Division
Department of Human Resources
12000 Government Center Pkwy, Suite 270
Fairfax, VA 22035
703-324-3316

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of loss of coverage due to the death of the employee, divorce, legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason if the County's health plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Administrator in the Benefits Division of the Department of Human Resources, 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035 (703-324-3316) of a disability or second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify the COBRA Administrator

in the Benefits Division in the Department of Human Resources, 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035 (phone number 703-324-3316) of that fact within 60 days of SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the COBRA Administrator in the Benefits Division of the Department of Human Resources, 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035 (phone number 703-324-3316) of that fact within 30 days of SSA's determination.

Second Qualifying Event
An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify the COBRA Administrator in the Benefits Division of the Department of Human Resources, 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035 (Phone: 703-324-3316 fax: 703-802-8795) within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Both the employee and the employee's spouse may elect continuation coverage, or only one of them can elect continuation coverage. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that under federal law, failure to continue your group health coverage will affect your future rights related to health plan coverage. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of continuation coverage may help you not to have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment rights at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay

may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. In the case of an extension of continuation coverage due to a disability, the premium may not exceed 150 percent.

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked (if mailed) or date received if sent via fax.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the County's health plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the County's health plan would have otherwise terminated, and must include all premiums due up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the COBRA Administrator in the Benefits Division of the Department of Human Resources, 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035 (703-324-3316) to confirm the correct amount of your first payment.

Your first payment should be made payable to **Fairfax County** and sent to:

COBRA Administrator
Department of Human Resources, Benefits Division
12000 Government Center Parkway, Suite 270
Fairfax, VA 22035

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the 15th of each month for the next month's coverage. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Periodic payments for continuation coverage should be sent to the address above. Credit cards and electronic payments are not accepted.

Grace periods for periodic payments

Although periodic payments are due on the 15th of the month, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Can you elect other health coverage besides continuation coverage?

Under the County's health plan, you have the right to elect alternative retiree coverage if you are eligible to retire and immediately receive a benefit from one of the Fairfax County Retirement Plans, or if you are an eligible County retiree covered by the Virginia Retirement System. If you elect this retiree coverage, you will lose all rights to the COBRA coverage. However your spouse and dependents will continue to have COBRA rights if they should lose coverage under the retiree plan due to divorce, legal separation, your death or if your dependent ceases to be eligible for coverage as a dependent.

For more information

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at *www.dol.gov/ebsa/*.

Keep your plan informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all group plans provide certificates of coverage to individuals who cease to be covered for any reason. The certificates of coverage are to be used by individuals who wish to show that they had group health coverage in order to ease the effect of a new plan's preexisting condition limitation period.

Under HIPAA, a preexisting condition period cannot be longer than 12 months (18 months for late enrollment, reduced by previous periods of creditable coverage). Individuals prove periods of creditable coverage by providing the certificates of coverage to their new plan administrator. Since none of the County's health insurance plans have preexisting condition limitations, you do not need to provide the County with a certificate when joining a County health plan. However, if you are electing coverage mid-year due to a qualifying event, you may be requested to provide a HIPAA certificate to demonstrate the type of coverage with which you were previously enrolled.

Under HIPAA, periods of creditable coverage prior to a 63-day break in coverage may be disregarded in determining whether that previous period of creditable coverage will reduce a preexisting condition limitation period. If you lose coverage under the County and have a break in coverage of 63 days or more before becoming covered by another group, the new plan can disregard all prior creditable coverage under the County plan in applying its preexisting condition limitation. COBRA coverage in most instances may be used until the coverage is available

HIPAA questions?

For more information on HIPAA, contact Medicare and Medicaid Services (CMS) at: *http://cms.hhs.gov/hipaa/hipaa1/default.asp*; or call 410-786-1565.

through a new plan. See the above section on COBRA to determine if you are eligible to continue the coverage with the County under the COBRA group.

HIPAA also requires employers to offer special enrollment periods for certain employees not currently covered under a County health plan. If you are covered under COBRA through another group plan and you choose not to enroll in the County plan when you are initially eligible, you may join a County health plan when your COBRA coverage is exhausted. In addition, if you do not have coverage with the County and gain a new dependent by birth, adoption, or marriage, you may enroll your newly eligible dependent(s), as well as yourself, during the special enrollment period. The special enrollment period is 60 days from the date of birth, adoption, or marriage. See the chart on pages 38-41 for more information on the special enrollment periods and to whom they apply.

If you wish to obtain more information on the HIPAA law, you may contact Medicare and Medicaid Services (CMS) at *http://cms.hhs.gov/hipaa/hipaa1/default.asp*; Phone: 410-786-1565 (not toll free).

Appendix 1, on page 58 and the HIPAA Notice of Privacy Practices, on page 62 of this booklet, contain information about the protection of individually identifiable health information under the HIPAA Privacy Regulations.

Newborns' and Mothers' Health Protection Act of 1996

This law includes important protection for mothers and their newborn children with regard to the length of hospital stays following the birth of a child. The law stipulates that "group health plans and health insurance issuers generally may not under Federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section." However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not under Federal law require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay less than 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

This law requires group health plans that provide coverage for medically necessary mastectomies to also provide coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to provide a symmetrical appearance; and
- prostheses and the treatment of physical complications during all stages of the mastectomy.

The County's plans cover mastectomies and the benefits required by this act.

Your Responsibility

Coordination of Benefits (COB)

Members of County health plans are required to furnish information about any other health or dental coverage with which they are enrolled.

When an individual has coverage under two health insurance plans, Coordination of Benefits (COB) is used to eliminate duplicate payments for the same services. CIGNA, BlueChoice POS and the BluePreferred PPO plans will pay only the difference between the benefits paid by the other plan and what they would have paid if there had been no other coverage. You will still be responsible for your normal out-of-pocket costs. This approach reduces the advantage of carrying coverage under two health insurance plans. When you have other coverage, you must provide authorization to your County health plan to obtain information or recover overpayments from the other plan.

Status changes and fraudulent or erroneous enrollment

At the time you enroll, you must certify that all statements in your application are true to the best of your knowledge. You are responsible for notifying the Employee Benefits Division of any status changes that affect the eligibility of, or premium payments for, any of your dependents (for example, if you and your spouse are divorced or if a child is no longer considered to be an eligible child under the County's plan).

If it is determined that a person covered in your application was ineligible at the time of enrollment, or later becomes ineligible, coverage for that person will terminate at the end of the month in which he/she became ineligible. You will be responsible for all claims payments or premium payments made by the County for the ineligible dependent.

Premiums paid by or on behalf of that person, for up to two months, may be refunded, except that any benefits already paid will be deducted from those premiums. Premiums paid for more than two months will not be refunded. If the costs incurred by the plan significantly exceed the premiums, you may be required to repay the County or the insurance company.

If it is found that an ineligible person was fraudulently enrolled in a plan, or an employee has attempted to claim benefits dishonestly in violation of the standards of conduct, recommendation for appropriate disciplinary action will be made, up to and including termination of employment.

Note: General limitations

No oral statement from any person shall modify or otherwise affect the benefits or terms and conditions of enrollment as set forth in this booklet.

Information about other health coverage must be furnished to the health plan in which you are enrolled, and all necessary documents and authorizations must be completed as requested by the health plan.

Retiree benefits

If you are covered under a County life, health and/or dental plan at the time of your retirement, you may continue the insurance under the retiree group. You have 60 days after your coverage ends as an active employee to elect to continue your coverage as a retiree. The County reserves the right to change or terminate the benefit provided or adjust the premium at any time. If you are not covered by a County life, health or dental plan at retirement, you are not eligible for retiree coverage.

Most of the information in this booklet applies to retirees as well as active employees. The information in this section is specific to retirees.

If you have retired from Fairfax County, you should contact the Retirement Administration Agency at 703-279-8200 or 800-333-1633 for information about continuation of health, dental, and/or life insurance coverage.

If you are currently enrolled in a County health or dental plan and choose to continue the coverage at the new premium rate, you do not have to submit a form during open enrollment .

If you would like to participate in a different health plan than the plan in which you are currently enrolled, you will need to submit an enrollment form. The fall open enrollment dates for retirees will be Oct. 23 through Nov. 17, 2006.

If you are currently enrolled in any County health or dental plan and choose to continue the coverage at the new premium rate, you do not have to submit a form during open enrollment .

For more information, contact:

Retirement Administration Agency
10680 Main Street, Suite 280
Fairfax, VA 22030

703-279-8200
800-333-1633

FAX: 703-273-3185

Who pays for retiree health and dental benefits?

Retirees pay the full cost of their health and/or dental insurance premiums. Health insurance premium rates are listed on page 34. Retirees age 55 or older, or those retired on a service-connected disability, receive a monthly subsidy from the County toward the cost of a County health plan. For 2007, the County has added an additional supplement. The 2007 subsidy is reflected in the table on next page:

Retiree Subsidy Amounts for 2007

Monthly Subsidy for Retirees Age 65 and Over			
Years of Service at Retirement	**Subsidy Amount**	**2007 Supplement**	**2007 Subsidy Amount**
5-9	$15	$15	$30
10-14	$25	$40	$65
15-19	$100	$55	$155
20-24	$150	$40	$190
25 or more*	$175	$45	$220
*Also includes retirees of any age who are approved for a service-connected disability retirement and covered under a County health plan and Police Officers who retire with unreduced benefits after 20 years of service.			

Monthly Subsidy for Retirees Ages 55-64			
Years of Service at Retirement	**Subsidy Amount**	**2007 Supplement**	**2007 Subsidy Amount**
5-9	$25	$5	$30
10-14	$50	$15	$65
15-19	$125	$30	$155
20-24	$150	$40	$190
25 or more*	$175	$45	$220
*Also includes retirees of any age who are approved for a service-connected disability retirement and covered under a County health plan and Police Officers who retire with unreduced benefits after 20 years of service.			

Surviving spouses are entitled to a subsidy only if they receive a Joint and Last Survivor benefit.

Retirees can pay their share of their health and/or dental insurance premiums in one of two ways. If possible, the cost will be deducted from the monthly annuity in the month prior to the month of coverage. If the individual does not receive an annuity, or if the retiree's annuity is not large enough to cover the monthly premiums, the retiree must pay their monthly premiums by mailing a personal check (payable to the County of Fairfax) to the Retirement Administration Agency. Personal checks must be received by the Retirement Administration Agency by the 10th of the month to cover the next month's coverage. Failure to make health and dental insurance payments on time may result in cancellation of the retiree's insurance coverage. Please remit personal checks, enrollment forms and change forms concerning retiree health/dental coverage to:

Retirement Administration Agency
10680 Main Street, Suite 280
Fairfax, VA 22030
703-279-8200 800-333-1633 fax: 703-273-3185

Retirees can pay their share of their health and/or dental insurance premiums in one of two ways.

1. If possible, the cost will be deducted from the monthly annuity in the month prior to the month of coverage.

2. If the individual does not receive an annuity or if the retiree's check is not large enough to cover the monthly premiums, the retiree must pay any amount not covered by their annuity by mailing a personal check to the Retirement Agency by the 10th of the month.

Retirees may decrease or drop coverage at any time. However, levels of coverage may only be increased outside of an open enrollment period due to a qualifying change in status. (See pages 38-41.)

Once dropped, coverage cannot be reinstated.

Continuous coverage requirement

The County requires retirees to have continuous coverage in a Fairfax County Government (FCG) health and/or dental plan. The County, however, allows the coverage to be transferred from the active County government employee group to the retiree group and vice versa. Transfers to and from the Fairfax County Public Schools (FCPS) is not allowed for purposes of retaining continuous coverage, as FCPS is a separate employer. Two examples follow:

Example 1: You are retiring and your spouse is also employed by FCG in a merit position. Your spouse may pick up coverage for both of you and any covered dependents when you retire. If your spouse is already enrolled in a FCG health plan, he or she may add you to the policy by filing an enrollment/change form with the Department of Human Resources within 60 days of your retirement date.

If your spouse terminates employment with FCG, you may pick up the coverage for both of you and any covered dependents through the Retirement Administration Agency by requesting the coverage within 60 days of your spouse's termination date. Coverage begins the first of the month after receipt of the enrollment form.

Example 2: You retire from FCG, then return to work for FCG in a merit position. The County will transfer your coverage back to the active employee group if you submit a new enrollment form to the Department of Human Resources within 60 days of your re-employment date. The effective date will be the first of the calendar month following receipt of the enrollment form by the Employee Benefits Division. At termination, your coverage will be transferred back to the Retirement Administration Agency if you complete another form requesting coverage through the retiree group. No break in coverage is allowed.

Retirees who wish to continue in a FCG health plan must apply for Medicare Part A and Part B as soon as they are eligible for that federal benefit. They do not need to apply for Medicare Part D.

After they receive Medicare coverage, Medicare becomes the primary source for payment of claims, and the FCG health plan becomes secondary.

Retirees whose retirement annuity has been suspended by the Retirement Administration Agency may pay for the full cost of their benefits by personal check as long as they are eligible to have their retirement benefits restored. If coverage is canceled by the retiree, or if a retiree's coverage is dropped because premiums have not been paid or because the retiree becomes ineligible, the retiree MAY NOT reenroll.

When can retirees make changes to their coverage?

New retirees have the following options within 60 days of retirement:

- You may continue in the same health plan that you had as an active employee until the next open enrollment period as long as you continue to meet the plan's eligibility and residency requirements. **Note:** CIGNA does not provide any coverage for retirees age 65 and older who are eligible for Medicare. Retirees or their dependents who become eligible for Medicare are not eligible to continue in Kaiser Permanente. The Kaiser Medicare Plus plan is only open to current members who were enrolled in the Medicare plan as of December 31, 2004.

- If you are no longer eligible for coverage in your current plan (either due to Medicare or because you live outside of the plan's service area), you must:

    - elect other coverage for which you are eligible. (see "Retirees Must Reside in Their Plan's Service Area" on page 31.)
    - reduce coverage level (drop dependents).
    - drop coverage altogether. However, once dropped, coverage may never be reinstated.

Current retirees have the following options:

- If you move out of your HMO's service area, you must change to another plan serving the area in which you live. The change must be made within 60 days of the move. (Note: retirees disenrolling from Kaiser Medicare Plus are required to complete the Kaiser Medicare Plus Disenrollment Form.)

- Retirees or dependents turning 65 become ineligible for coverage in Kaiser and CIGNA. You must change to another plan serving the area in which you live. The change must be made within 60 days of becoming eligible for Medicare. NOTE: coverage will be cancelled with CIGNA or Kaiser on the date that an individual becomes eligible for Medicare. Enrollment in the new plan will be made retroactive to that cancellation date once the enrollment form is processed.

Retirees may **decrease coverage** (drop coverage or drop family members from their insurance) **at any time**. However, dependents may be added and levels of coverage may only be increased outside of an open enrollment period **due to a qualifying change in status**. Changes will take effect on the first of the month after receipt of the form, unless another date is required due to the specific qualified event. (see charts on pages 38-41)

Retirees eligible for Medicare

Retirees who become eligible for Medicare **must apply for Medicare Part A and Part B as soon as they are eligible** for that federal benefit. After you receive Medicare coverage, Medicare becomes the primary source for payment of claims, and the FCG health plan becomes secondary. Retirees are not required to elect Medicare Part D.

Retirees or dependents must submit a copy of their Medicare card to the Retirement Administration Agency showing the effective dates of Part A and Part B coverage. The monthly premium for Medicare Part B will be deducted from their Social Security check. Retirees must submit a copy of their Medicare card to the Retirement Administration Agency as soon as it is available – up to three months prior to the effective dates. Submitting a copy of the card in this timely manner will limit the need for any retroactive adjustments in your check and will insure that claims are paid correctly.

For most FCG health insurance plans, retirees with Medicare are responsible for paying the same deductible, co-payment, coinsurance and other out-of-pocket expenses that they would have been responsible for paying prior to receiving

If a retirement-eligible active employee dies prior to actual retirement, his/her spouse may continue health and/or dental insurance through the Retirement Agency until he or she remarries.

If an employee dies prior to becoming eligible for retirement, survivors are eligible only for continuation coverage under COBRA.

Medicare. However, under the BlueChoice POS plan, referrals for specialists are not required.

Retirees and dependents who have Medicare Part A and Part B coverage may be eligible for reduced health insurance premiums. Retirees who do not apply for and maintain Medicare Part A and Part B coverage will be responsible for the portion of their claims that Medicare would have paid.

Medicare Part D

Medicare's open enrollment for Medicare Part D prescription drug coverage will run from November 15, 2006 to December 31, 2006. During this timeframe, Medicare-eligible retirees, spouses and dependents will have an opportunity to enroll in this federal program that provides partial coverage of outpatient prescription drugs for individuals who elect this benefit. Retirees who are covered by the County's health plan must decide whether they will keep their County coverage, drop their County coverage and enroll in a Medicare Part D plan, or have both types of coverage.

To encourage employer plans to continue to provide pharmacy benefits to their retirees, the Centers for Medicare and Medicaid Services (CMS) will be providing a rebate to employers who retain retiree pharmacy benefits under their health plans. The rebate will be provided for each retiree who does not enroll in Medicare Part D.

Although the County's health plans offer prescription drug benefits that are as good as or better than Medicare's standard benefit, Medicare-eligible retirees should evaluate both the County plan and the Medicare Part D plan to determine which plan is best for them. In making their decision, retirees will need to keep in mind the subsidy that they will receive under the County plans for 2007. Retirees must also understand that if they drop the County's plan, they will not be able to re-join the plan in the future. Retirees will, however, be able to enroll in a Medicare prescription drug plan in the future, without a late enrollment penalty, as long as they remain covered under the County's plan.

During 2007, the County plans to explore other options for providing coverage for retirees with Medicare.

Coverage for surviving spouses

Surviving spouses of deceased retirees may continue health and/or dental insurance coverage until they remarry. Surviving children may continue their coverage until they become ineligible because of age or loss of dependent status. If the survivors are not covered under a County plan at the time of the retirees' death, they are not eligible for coverage.

If a retiree or dependent with coverage dies, please contact the Retirement Administration Agency as soon as possible so that premiums can be adjusted.

Surviving spouses who are age 55 or older and who receive a survivor's benefit from the County are also eligible to receive a monthly subsidy (see chart on page

27). Surviving spouses who do not receive a survivor's benefit are not eligible for any subsidy.

If an active employee dies prior to retirement, his/her spouse may continue health and/or dental insurance through the Retirement Administration Agency if he/she is eligible to immediately receive a retirement annuity. This coverage may continue until he or she remarries. Surviving children may continue their coverage until they are no longer eligible. Surviving spouses of retirement-eligible active employees who are age 55 or older are also eligible to receive a monthly subsidy from the County if they elect to receive an annuity.

If an employee dies prior to becoming eligible for retirement, his/her survivors are eligible only for continuation coverage under COBRA (see page 20). Survivors of retirees who become ineligible for coverage may also be eligible for COBRA coverage. Call Human Resources at 703-324-3316 for more information.

Kaiser Permanente Medicare Plus Plan

Kaiser Permanente's Medicare Plus plan is available for members who were enrolled in this plan as of December 31, 2004. New retirees or their dependents who are age 65 and current retirees or their dependents who turn 65 must choose other coverage. To remain eligible for this coverage, current members must live within the plan's service area (and not reside out of the service area for more than 90 days per year). If the retiree or dependent loses eligibility for this plan, the County will allow the retiree to change to another health plan within 60 days of the loss of eligibility so that he/she is covered in a County health plan continuously.

The Kaiser Medicare Plus plan is only open to current members who were enrolled in the Medicare plan as of December 31, 2004.

Retirees or their dependents who turn 65 (or who are 65 at retirement) must enroll in another plan for which they are eligible.

Retirees under the Kaiser Medicare Plus plan must use Kaiser Permanente providers in order to receive non-emergency benefits from Kaiser. However, they may use their Medicare card at other providers to receive Medicare benefits for any covered service. To disenroll from this plan (even to change to another plan), retirees must complete a special disenrollment form that is available from the Retirement Office at 703-279-8200 or 800-333-1633. The completed form must be returned to the Retirement Administration Agency.

Retirees must reside in their plan's service area

BlueChoice POS and Kaiser Permanente health plans require retirees to live in one of the zip codes that make up their service area. If your zip code (based on your address on file with the Retirement Administration Agency) is not included in the service area, you must elect other coverage. This is true even if you change your address for a short time or if your home is in the service area but the post office with your zip code is out of the service area. A general description of the service area for each plan is listed below.

For information about specific zip codes covered by each plan, consult the plan materials or call the customer service number for your plan. If you move outside of the service area of your plan, you MUST notify the Retirement Administration Agency and change to a new plan within 60 days of your move. Failure to do so could result in your claims not being paid or the loss of eligibility for coverage under the retiree group.

If you move into the service area of a plan, you must wait until the annual open enrollment period to enroll in that plan.

HEALTH PLAN SERVICE AREAS

BlueChoice POS

Arlington, Alexandria, Fairfax County and City, Falls Church, Prince William County, City of Manassas, City of Manassas Park, Loudoun County, Leesburg, the entire state of Maryland and DC.

Kaiser and Kaiser Medicare Plus

DC, Maryland: Baltimore, Montgomery, Carroll, Harford, Anne Arundel, Prince George's and Howard Counties and some of Calvert, Charles, Frederick County; Virginia: Arlington, Alexandria, Fairfax, Prince William, Loudoun, Falls Church, Manassas and Manassas Park.

CIGNA OAP and CareFirst BluePreferred PPO

Both have nationwide networks.

Retiree Life Insurance

Benefit Reduction Schedule

Coverage reduces to 65% of the original amount on the first of the month after the date you turn age 65 or after the date your coverage ends under the active employee group, whichever occurs first. Coverage reduces again to 30% of the original amount on the first of the month after you turn age 70.

Coverage Options

Retirees may elect any life insurance option that is equal to or less than their current coverage option in effect immediately prior to retirement. For example, an employee with Basic + Optional Two Times Salary, could choose to continue Basic + Optional Two Times Salary, or elect a lower option (Basic + Optional One Times Salary, Basic, or Reduction to $12,500). Retirees can reduce their coverage to a lower option at anytime. The benefit reduction schedule applies to all coverage options.

County and Retirees Contribution

The following chart outlines the county's contribution as well as the retiree's contribution for the various options offered.

Coverage	County Portion	Retiree Portion
Reduction to $12,500 (<age 80)	50% of coverage	50% of coverage
Reduction to $12,500 (age 80 +)	100% of coverage	0% of coverage
Basic (no Optional coverage)	50% of Basic coverage	50% of coverage
Basic + Optional 1x Salary	100% of Basic coverage	100% of Optional
Basic + Optional 2x Salary	100% of Basic coverage	100% of Optional
Basic + Optional 3x Salary	100% of Basic coverage	100% of Optional
Basic + Optional 4x Salary	100% of Basic coverage	100% of Optional

The rates for retirees are two cents less than the age banded rates for active employees because of the discontinuation of Accidental Death and Dismemberment coverage. The monthly premium rates for dependent coverage are the same premium rates that active employees pay. The coverage level for dependent coverage follows: High option is $12,500 for your spouse and $6,250 for your eligible dependent children; Low option is $6,250 for your spouse and $2,500 for your eligible dependent children. The County does not make a contribution for dependent coverage.

Age	Monthly Premium Rate per $1,000 of coverage
Under 30	$0.07
30-49	$0.15
50-59	$0.29
60-79	$0.47
80-84	$4.02
85-89	$6.81
90-94	$19.99
95+	$38.73

Long-Term Care Insurance

Long-term care refers to services you may need if you become unable to care for yourself. Long-term care insurance provides a daily benefit when you are unable to perform at least two of the six activities of daily living, defined as: bathing, dressing, eating, transferring, toileting and continenance, or when you have a severe cognitive impairment such as Alzheimer's disease. You must elect this coverage in order to be enrolled. You choose where you want your care: at home, an assisted living facility, nursing home, adult day care or hospice. Benefits begin after a 90-day waiting period.

Retirees, spouses of retirees, surviving spouses of retirees and adult children of retirees may apply for the coverage at any time. Applicants must complete an enrollment form and a medical questionnaire, and be approved by Aetna. Forms may be downloaded at http://www.aetna.com/group/fairfaxcounty or you may call the Aetna hotline at 800-537-8521 or Human Resources at 703-324-3437 for more information. (see page 54).

Health And Dental Insurance Premiums For Retirees
JANUARY 1, 2007 – DECEMBER 31, 2007

	Full Monthly Premium (before applying any subsidy)
BlueChoice POS	
Individual	$ 452.20
2 Party	$ 888.66
Family	$ 1,306.94
Individual with Medicare	$ 315.80
2 Party with Medicare	$ 631.59
2 Party (1 Medicare/ 1 Non Medicare)	$ 768.00
Family, 1 Medicare	$ 1,218.44
Family, 2 Medicare	$ 1,129.94
Family, 3 Medicare	$ 1,041.44
BluePreferred PPO	
Individual	$ 520.02
2 Party	$ 1,021.96
Family	$1,503.00
Individual with Medicare	$ 363.18
2 Party with Medicare	$ 726.35
2 Party (1 Medicare/ 1 Non Medicare)	$ 883.20
Family, 1 Medicare	$1,414.50
Family, 2 Medicare	$1,326.00
Family, 3 Medicare	$1,237.50
Kaiser	
Individual	$ 349.26
2 Party	$ 680.49
Family	$1,012.58
Individual with Medicare	$ 285.56
2 Party with Medicare	$ 570.36
2 Party (1 Medicare/ 1 Non Medicare)	$ 634.06
CIGNA	
Individual	$358.62
2 Party	$699.34
Family	$1,043.58
DELTA DENTAL	
Individual	$ 32.24
2 Party	$ 60.88
Family	$100.32

Health insurance terms defined

Explanations for the terms used in the charts and throughout this booklet are provided below:

BlueChoice POS - The name of the provider network offered by Blue Cross and Blue Shield of the National Capital Area.

Brand Name Drug - A drug that is sold by one company. It is manufactured by a pharmaceutical company that has chosen to patent the drug's formula and register its brand name. Brand name drugs are chemically equivalent to their generic counterparts, and generally more expensive than generic drugs.

Coinsurance - After you meet your deductible, the plan will begin to pay a percentage of your covered expenses. This percentage is the plan's coinsurance. The percentage you pay is your coinsurance.

Co-payment - A co-payment, or co-pay, is the amount of the covered expense you are responsible for paying at the time you receive care when you see an HMO provider or a PPO provider.

Covered Services - The insurance contract specifies that certain services are covered and others are not. Those that are covered are generally the kinds of services needed to keep you healthy or take care of you when you are sick or injured. Typical services not usually covered are cosmetic surgery, custodial care, long-term rehabilitation and long-term treatment for drug or alcohol abuse.

Deductible - This is an amount that you must pay before some plans will begin to pay toward your medical costs. For example, if your deductible is $250 per calendar year, you must pay the first $250 in covered medical expenses before plan benefits will begin. After you have paid the deductible amount, the plan begins to pay its share of your covered medical expenses.

Formulary Drug or Preferred Brand Name Drug - A list of preferred, commonly prescribed brand name prescription drugs. These drugs are chosen by a team of doctors and pharmacists because of their clinical superiority, safety, ease of use and cost. These drugs are on the middle tier of a 3-tier prescription program.

Generic Drug - A drug that may be sold under more than one name by more than one company. It has the same active-ingredient formula as a brand-name drug. A generic drug is known only by its formula name and its formula is available to any pharmaceutical company. Generic drugs are generally less expensive than brand name drugs.

Health Maintenance Organizations (HMOs) - An HMO emphasizes wellness and preventive care. You pay a flat fee and the HMO covers most of your medical costs. There are no deductibles, but there may be small co-payments for office visits and prescriptions.

When you join an HMO, you select your primary care physician (PCP) from the HMO's list of doctors or if the HMO is a staff model, you may select your center or a primary care physician at a particular center. Your primary care physician is the doctor you usually see whenever you need medical care. (In most HMOs, women may also self-refer to a gynecologist in addition to a primary care physician.)

If you need a specialist, the primary care doctor will refer you to one who is affiliated with the HMO. If you need hospitalization, you will be referred to a hospital that has a contract with the HMO, and usually all your hospital costs will be covered by the HMO. It is important to note that your coverage is with the HMO-plan and not a particular doctor. If your doctor leaves the HMO plan, you must select another provider.

There are two kinds of HMOs:

- In one model, staff doctors and nurses are located at a medical center and generally work directly and exclusively for the HMO. You go to that facility for your appointments. Specialists may be located at the facility or at their own offices elsewhere. Kaiser Permanente is this type of HMO.

- The second model is called an individual practice association (IPA). Here doctors have their own offices and you go to the office of your primary care physician for treatment. Your doctor may be a member of more than one IPA-type HMO and also may participate in BCBS and other health plans.

In both types of HMOs, you do not have to file claim forms. You make a small co-payment, if applicable, at the time of the visit, and the plan takes care of all the paperwork.

HMOs have specific geographical service areas. While you cannot normally change health plans except during the annual open enrollment period, members who move out of their HMO's service area may switch to another plan for which they are eligible without waiting for the open enrollment period. The Employee Benefits Division must receive your request for this change and the applicable enrollment forms within 60 days after your change of residence.

There are two kinds of HMOs:

In one model, staff doctors and nurses are located at a medical center and generally work directly and exclusively for the HMO. You go to that facility for your appointments. Specialists may be located at the facility or at their own offices elsewhere. Kaiser Permanente is this type of HMO.

The second model is called an individual practice association (IPA). Here doctors have their own offices and you go to the office of your primary care physician for treatment. Your doctor may be a member of more than one IPA-type HMO and also may participate in BCBS and other health plans.

Non-Preferred Drug - Term used to identify prescription brand name drugs that are not listed on an insurance company's drug formulary. These drugs are on the 3rd tier of a 3-tier prescription program and have the highest level of co-pay.

OAP – The CIGNA Open Access Plus plan allows members to see any licensed provider, though benefits are higher if they receive care from a provider in the nationwide Open Access Plus network. Members are encouraged, but not required, to pick a primary care physician and no referrals are necessary to see a specialist.

Out-of-Pocket Maximum - The most you will pay in coinsurance (not co-payments) in a calendar year before the plan pays 100 percent of covered expenses.

Plan Allowance - Plan allowances are generally the contracted rates or fee schedules which participating providers have agreed to accept from the plan as payment under this program. Nonparticipating providers may bill you for any

balance above the plan allowance. In any event, you will be responsible for any applicable deductibles and coinsurance and both participating and nonparticipating providers may bill you directly for such amounts.

POS (Point of Service) - An HMO-type plan that allows members to self refer out of the network, subject to higher fees than if care were received from the HMO-type network.

PPO (Preferred Provider Organization) – A network-based, managed care plan that allows the participant to choose any health care provider. However, if care is received from a "preferred" (participating in-network) provider, there are generally higher benefit coverages and lower deductibles.

Pre-certification - An administrative procedure whereby a health care provider contacts the plan before treatment begins.

Premium - A health insurance premium is the amount a health plan charges to provide you with health insurance coverage. Premiums normally are collected monthly, and are divided into two parts, the County's share and the employee's share. For active employees, the County's share is by far the larger of the two. The employee's share, what you pay, is deducted from your biweekly paycheck, prior to taxes, during the month of coverage.

In some special cases described earlier in this booklet, there is no County contribution and the participant pays the entire cost.

Primary care provider - An in-network doctor you choose from a directory of providers. This doctor coordinates the care you receive.

UCR – **"**Usual customary and reasonable" fee. UCR is the amount that is allowed for benefit consideration under out-of-network services. This fee is determined by the plan to be the acceptable maximum in a particular zip code area for a specific procedure. If your physician or dentist charges more than the UCR, the plan will only calculate benefits on the UCR amount. You will be responsible for the difference in addition to your coinsurance.

QUALIFYING CHANGE IN STATUS EVENTS

The following events, as specified in Section 125 of the Internal Revenue Code, the Health Insurance Portability and Accountability Act (HIPAA) and other federal regulations, govern the occasions when you can enroll, cancel or change your coverage OUTSIDE of the open enrollment period. The change requested must be on account of, and consistent with, the qualifying event. If the requested change does not meet both the qualifying event and consistency rules, the request for change cannot be approved. **NOTE**: A voluntary cancellation is not a qualifying event.

In order to make changes to your health, dental and/or flexible spending account coverage, you must file the appropriate form within 60 days of the qualifying event. Change forms must be received by the Employee Benefits Division of the Department of Human Resources within 60 calendar days of the qualifying event or loss of coverage, whichever is later. If the change is due to birth, adoption, placement for adoption or due to dependent's loss of eligibility for other coverage, any benefit plan may be elected. **All changes take effect the first of the month following receipt of the form, except for birth, adoption or placement for adoption, which become effective on the date of birth or adoption.**

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.	ACTIONS ALLOWED
Marriage	To add a spouse and any eligible dependents, file a change form within 60 days of the marriage. To drop County health plan coverage because you will be covered by your new spouse, file a change form within 60 days of the marriage. Uninsured employees may enroll, add a spouse and all newly eligible dependents (i.e. stepchildren).	Fairfax County Enrollment/Change form; and A copy of your marriage certificate and birth certificates for any children for whom you are requesting coverage (or proof of birth letter for newborns). You must also notify Social Security and Payroll of any name change.	Health/Dental Ins. – May enroll, add spouse/eligible children, or drop coverage if enrolling under spouse's plan* Health FSA – May increase or elect coverage. May decrease or cease coverage if consistent with qualifying event Dep. Care FSA – May increase or elect coverage.
Birth of a child	To add a newborn child, a change form must be filed with the Employee Benefits Division within 60 days of birth. Spouse and other newly eligible dependents may also be added. Uninsured employees may enroll, add a spouse and all newly eligible dependents (i.e. stepchildren).	Fairfax County Enrollment/Change form; and A copy of your child's birth certificate (or proof of birth letter). Marriage certificate, and birth certificates for other children, if applicable.	Health/Dental Ins. – May enroll, add dependent, or drop coverage if child and all covered dependents are enrolling under spouse's plan. Health FSA – May increase or elect coverage. Dep. Care FSA – May increase or elect coverage.
Adoption or placement for adoption	Change form must be filed with the Employee Benefits Division within 60 days of adoption or placement for adoption. Spouse and other newly eligible dependents may also be added. Uninsured employees may enroll, add a spouse and all newly eligible dependents (i.e. stepchildren).	Fairfax County Enrollment/Change form; and Legal documentation showing date of adoption or legal placement. Marriage certificate, and birth certificates for other children, if applicable.	Health/Dental Ins. – May enroll, add dependent, or drop coverage* if child and all covered dependents are enrolling under spouse's plan. Health FSA – May increase or elect coverage. Dep. Care FSA – May increase or elect coverage.
Divorce	To drop your former spouse and children who are not your dependents, file a change form within 60 days of the divorce. If you have lost coverage through your spouse as a result of divorce, file change form within 60 days of loss of coverage to elect coverage with the County.	Fairfax County Enrollment/Change form; and Copy of the first and last page of the divorce decree; and HIPAA certificate or letter from spouse's health plan or employer showing the date the coverage ended (for employees who are electing coverage due to loss of coverage under the former spouse's plan).	Health/Dental Ins. – May enroll if other coverage* is lost. Must drop coverage for ex-spouse and ineligible dependent children. Health FSA– May elect coverage or increase coverage if employee or dependent loses eligibility under spouse's plan. May decrease coverage or cease future contributions. Dep. Care FSA – May increase, decrease or cease future contributions, if consistent with qualifying event

QUALIFYING CHANGE IN STATUS EVENTS (continued)

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.	ACTIONS ALLOWED
Obtaining legal guardianship or permanent legal custody of a child	A change form must be filed with the Employee Benefits Division within 60 days of the date legal guardianship/permanent legal custody is granted.	Fairfax County Enrollment/Change form; and Court documents showing that the employee has been appointed legal guardian for the child or has been given permanent legal custody. (Not simply a change in custody.)	Health/Dental Ins. – May enroll, add dependent, or drop coverage* if added to spouse's coverage Health FSA – May increase or elect Dep. Care FSA – May increase or elect
Death of employee, spouse or dependent	File a change form within 60 days of date of death. If the employee who was previously covered under spouse's plan, he/she may elect coverage under Fairfax County's plan within 60 days. Spouse or dependents who were covered under Fairfax County's plan must be removed within 60 days. Effective date is the end of the month in which the employee died.	Fairfax County Enrollment/Change form; and HIPAA certificate or letter from spouse's health plan or employer showing the date the coverage ended (for employees who are electing coverage due to loss of coverage under the spouse's plan).	Health/Dental Ins. – May enroll if other coverage* is lost. Must remove deceased spouse/dependent from plan. Health FSA – May elect, increase or decrease coverage, if consistent with event. Dep Care FSA – May elect, increase or decrease coverage, if consistent with event.
Dependent child reaches plan age limit or ceases to meet eligibility requirements under the plan.	To drop a dependent, file a change form within 60 days of the status change.	Fairfax County Enrollment/Change form.	Health/Dental Ins. – Ineligible dependent may enroll in COBRA continuation coverage. Health FSA – May decrease or cease future contributions, if consistent with qualifying event. Dep. Care FSA – May decrease or cease future contributions, if consistent with qualifying event.
Change in employment status of the employee or spouse that affects health or dental coverage, including: - termination or commencement of employment; - strike or lockout; - commencement of or return from an unpaid leave of absence; - change in worksite or any other change in employment status that results in an employee, spouse or dependent becoming eligible for or losing eligibility for coverage; - cessation of employer contributions toward premium; - spouse's employer no longer offers coverage to the class of employees that include the spouse.	To elect coverage with the County, file a change form within 60 days of loss of coverage. To add spouse/dependents who had been covered under spouse's plan, file a change form within 60 days of loss of coverage.	Fairfax County Enrollment/Change form; and A copy of your marriage certificate or last tax return indicating filing married (if adding spouse) and birth certificates for children (or proof of birth letter for newborns); and HIPAA certificate or letter from other plan documenting date coverage was lost, family members who were covered and type of coverage with which you were enrolled.	Health/Dental Ins. – May enroll, increase or decrease coverage election*, consistent with qualifying event Health FSA – May elect, increase, decrease, or cease future contributions, if consistent with qualifying event. Dep. Care FSA – May elect, increase, decrease, or cease future contributions, if consistent with qualifying event.
	To drop County coverage, file a change form within 60 days of the effective date of coverage under the other plan.	Fairfax County Enrollment/Change form	

QUALIFYING CHANGE IN STATUS EVENTS (continued)

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.	ACTIONS ALLOWED
Employee or dependent reaches lifetime limit for ALL benefits.	File change form within 60 days of reaching lifetime limit or within 60 days of first claim denied for that reason.	Fairfax County Enrollment/Change form; and Health plan documentation with proof that lifetime limit has been reached.	Health/Dental Ins. – May drop coverage or make a new coverage election. Health FSA – None Dep. Care FSA – None
Employee or dependent becomes entitled to Medicaid or Medicare (does not apply to State Children's Health Insurance Program)	File change form to drop coverage or remove dependent within 60 days of Medicaid or Medicare entitlement.	Fairfax County Enrollment/Change form.	Health/Dental Ins. – May drop or reduce coverage. Health FSA – May decrease or cease future contributions. Dep. Care FSA – None
Employee or dependent loses eligibility for Medicare or Medicaid or State Children's Health Insurance Program or COBRA coverage (must be involuntary).	File enrollment or change form within 60 days of coverage loss to add or increase coverage under the plan.	Fairfax County Enrollment/Change form; and Copy of official notification letter indicating loss of eligibility and reason for loss of coverage; and If adding spouse or eligible dependent children, copy of marriage certificate/tax form and birth certificates for children.	Health Ins. – May enroll (if employee was covered by Medicare or Medicaid) or add dependents Health FSA – May elect, increase decrease or cease future contributions if consistent with qualifiying event. Dep. Care FSA – None
Court orders (including judgments, decrees or qualified medical child support orders)	File change form to add or drop coverage within 60 days of event (change must be consistent with the court order and the order must be directed to the County and not to any to any other party).	Fairfax County Enrollment/Change form; and Copy of court order; and If dropping your child(ren) because someone else has been ordered to provide coverage, proof that child(ren) have been enrolled in other coverage. Effective date is determined by court order.	*If ordered to add dependent*: Health/Dental Ins. – May enroll (if consistent with order) or add dependent Health FSA – May elect or increase Dep. Care FSA – None *If dropping coverage*: Health/Dental Ins. – May reduce coverage and make a new coverage election*. Health FSA – Decrease or revoke Dep. Care FSA – None
Employee moves and no longer resides within the HMO's service area or spouse's HMO coverage is lost because he or she no longer lives or works in the service area of that HMO and no alternative coverage is available from his or her employer.	To change health plans or drop coverage, file a change form within 60 days of the change of residence.	Fairfax County Enrollment/Change form; and Documentation showing change in address; and. If electing or changing coverage because of cancellation of spouse's coverage due to no longer living or working in the HMO's service area, copy of HIPAA certificate or other document from spouse's employer.	Health Ins. – Change to another plan for which you are eligible or drop coverage Dental Ins, Health FSA and Dep.Care FSA. -- None

QUALIFYING CHANGE IN STATUS EVENTS (continued)

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.	ACTIONS ALLOWED
Commencement of unpaid FMLA Leave:	No action is required; employee will continue with same health/dental coverage election in effect provided that premiums are paid. Employee share of premium is due while on FMLA leave. May elect to drop coverage while on unpaid FMLA leave.	Fairfax County Enrollment/Change form if dropping coverage	Health/Dental Ins. – May decrease or drop coverage Health FSA – May cease future contributions, prepay contributions or continue to pay as they become due. Dep. Care FSA – May cease future contributions, prepay contributions or continue to pay as they become due.
Return from unpaid FMLA Leave:	If coverage was dropped, may elect to be reinstated to coverage in effect prior to FMLA leave.	Fairfax County Enrollment/Change form	Health/Dental Ins. – May make new election if coverage was dropped. Health FSA – May: • resume coverage at original level and pay for missed contributions, • resume coverage at a level that is prorated and continue resume contributions at the same level as before FMLA • make new election at any open enrollment period while on FMLA Dep. Care FSA – May: • resume coverage at original level and pay for missed contributions, • resume coverage at a level that is prorated and continue resume contributions at the same level as before FMLA • make new election at any open enrollment period while on FMLA
Open enrollment of a spouse	If your spouse has a different plan year than the County's calendar year coverage period, you can change your health coverage election on account of an action that your spouse has taken that affects your coverage under his/her plan. NOTE: If spouse's plan year is the same as the County's plan year, you must make your change during the County's open enrollment period. To pick up coverage with the County, file a change form within 60 days of loss of coverage. To drop coverage with the County, file a change form with 60 days of the effective date of the new coverage.	Fairfax County Enrollment/Change form; and A copy of your marriage certificate or last tax return indicating filing married and birth certificates for children (or proof of birth letter for newborns). To request that County coverage be dropped, file a change form within 60 days of the effective date of the new spouse coverage.	Health/Dental Ins. – May make a change that corresponds with the change made by spouse*. Health FSA – None Dep. Care FSA – Enroll, increase, decrease or cease if consistent with qualifying event
Change in daycare providers or cost of a provider's services	To change Dependent Care FSA contribution for remainder of the year due to a change in providers or change in cost of a provider's services (excluding changes in costs if provider is a relative) file an enrollment/change form within 60 days of the qualifying event.	Fairfax County Enrollment/Change form and Documentation showing the new provider and change in cost.	Dep care FSA only – Enroll, increase or decrease or cease if consistent with qualifying event.

*You may enroll in dental coverage (or drop dental coverage) if a consistent change is also being made to other comparable coverage (i.e. you add your spouse to your dental coverage because your spouse lost dental coverage due to a change in employment status.)

Deferred Compensation

The County offers a deferred compensation plan to all benefit eligible employees. The County's plan is governed by Section 457 of the Internal Revenue Code.

The Plan allows employees the opportunity to make contributions into a tax deferred investment account through payroll deductions and save additional money for retirement. The deferred income and accrued earnings on your investment account are sheltered from federal and state income taxes. You pay income taxes on these amounts when withdrawn from the plan (generally at retirement).

Maximum contributions allowable per calendar year

The 457 plan contribution limit is the lesser of (1) 100 percent of taxable compensation or (2) the normal contribution limit in effect that year.

Beginning in the year you reach age 50, you may make additional annual contributions as noted in the chart below. If you have underutilized deferrals, you may also contribute 'catch-up' amounts. Participants age 50 and older may use the age 50 limit, regardless if there are underutilized deferrals.

The regular catch-up limit is twice the limit in effect for normal contributions ($31,000 for 2007). The catch-up amount is determined by subtracting the actual amount deferred for each plan year from the maximum amount allowed by law for each of those years. Regular 'catch-up' is only available to employees who qualify for normal (unreduced) retirement in less than four years. The contribution limits for 2007 follow:

Year	Normal Limit	Age 50 Limit	Regular Catch-up
2007	$15,500	$20,500	$31,000

The 457 Plan has a single aggregate limit that incorporates deferrals under every 457 plan. Therefore, if you had or have 457 contributions through another employer, you need to ensure that the combined contributions do not exceed the 457 limits for the year. Contributions made to other plans such as a 401(k) or 403(b) will not impact the amount you are able to defer in a 457 plan.

Withdrawing your money

It is important to remember that monies contributed to the Deferred Compensation plan are intended for retirement. Participants may not withdraw assets at any time. Assets may be withdrawn from your account only under the following conditions:

Who to contact

ICMA Retirement Corporation
800-669-7400
www.icmarc.org

T. Rowe Price
888-457-5770
www.troweprice.com

AIG-VALIC
888-568-2542
www.agrsretirenet.com /Fairfax

Nationwide Retirement Solutions
800-769-4457
www.nationaldeferred.com

County Benefits
703-324-3374

Financial Benefits Help Desk
703-324-4995
***Mitch Falte**r, AIG-VALIC*
***Craig Brown**, ICMA*
***Marjorie Allen**, Nationwide*

- **Retirement**
- **Termination of employment**
- **Unforeseeable emergency** - This is defined as a severe financial hardship resulting from a sudden illness, disability, accidental property loss, or other extraordinary circumstance arising as a result of events beyond your control. This withdrawal option is subject to strict IRS guidelines.
- **Small balance account withdrawals** – You are eligible to initiate a one-time disbursement of your account if the balance is $5,000 or less and you did not contribute to the plan for at least two years.

Rollovers into, or out of, 457 Plans

The Economic Growth and Tax Relief Reconciliation Act (EGTRRA) includes a provision which allows portability of retirement assets between (to and from) retirement plans (such as 401, 403(b), governmental 457 plans and Traditional IRAs) if the plans permit such portability. Fairfax County's Deferred Compensation Plan allows for rollovers of eligible assets to the plan.

Upon separation from County service, participants may elect to roll their Deferred Compensation assets to another plan or IRA if the distribution is an "eligible rollover distribution." Participants may also request a plan-to-plan transfer from the 457 plan to a defined benefit plan for the purchase of permissive service credit, if the receiving plan provides for such credit.

Flexible 457 distribution rules

457 plan participants have the same distribution options as participants under other plans. This means that participants are allowed to stop and restart their distributions, as well as to increase and decrease distributions, by filing the appropriate request with the plan provider.

You may choose a beginning payout date at **any time** *after the date* you retire or terminate employment. You must begin receiving distribution no later than April 1 of the calendar year following the year in which you reach age 70½ or sever from employment.

The 457 plan allows distributions at any age and it does **not** have a 10 percent penalty on distributions received prior to age 59½. If you rolled assets into your 457 plan from another type of plan (i.e. 401, or 403(b)), these assets may be subject to the 10 percent penalty tax if you subsequently withdraw them from your 457 plan before you reach age 59½.

You have a number of distribution options to choose from (i.e., lump sum, partial lump sum, and scheduled installment payments). You may choose monthly, quarterly, semi-annual or annual payments. You are also allowed to change your distribution at will. This means you can increase, decrease, stop or start your distribution(s) at any time. Contact the deferred compensation provider(s) with which you participated to request a distribution packet or a rollover form.

When you can withdraw assets

You can withdraw assets from your account under the following conditions:

- Retirement
- Leaving employment
- Unforeseeable emergency
- Small balance account withdrawal

Is there a penalty?

You do not have a 10 percent penalty tax on distributions received prior to age 59 ½.

The County's investment providers

- AIG-VALIC – offers 15 funds
- ICMA Retirement Corporation – offers 23 funds
- Nationwide Retirement Solutions – offers 18 funds
- T. Rowe Price – offers 22 funds

Investment providers available

There are four investment providers that offer investment options for County employees. Employees are permitted to have accounts with all four providers. They can also defer biweekly deductions to four plan providers at the same time. The four providers are:

AIG-VALIC – offers 15 funds
ICMA Retirement Corporation – offers 23 funds
Nationwide Retirement Solutions – offers 18 funds
T. Rowe Price – offers 22 funds

The funds span multiple investment categories, such as small, mid and large cap equities, international funds, index funds, stable value funds, asset allocation funds, and life cycle/retirement target date funds. The quarterly returns for the various funds can be found on the Benefits web site on the County's infoweb and can be obtained from the Benefits Division in the Department of Human Resources.

Enrollment, change and transfer requests

To enroll in the deferred compensation plan for the first time, or to enroll for the first time with a new provider, simply complete the form entitled "Fairfax County Government 457 Plan New Enrollment Form" and return it to the Employee Benefits Division in the Department of Human Resources.

If you are already enrolled but want to change your deduction amount, mailing address or beneficiary, complete the form entitled "Fairfax County Government 457 Employee Change Form".

New enrollments and monetary change requests received by the Department of Human Resources in any month will become effective the first available payday of the next month.

To transfer money from one of the County's investment providers to another provider within the County Plan, complete the form entitled "Fairfax County Government, 457 Plan Request to Move Deferred Compensation Assets Form". Forms are processed daily and changes will be posted within 5 business days after received in good order.

Forms can be requested from the Benefits Division of the Department of Human Resources, from your agency payroll contact, or downloaded from the Benefits web site on the County's Infoweb.

Anytime you want to change your investment allocations or transfer money between funds within the same provider, simply call the provider's toll-free number:

ICMA Retirement Corporation	800-669-7400
T. Rowe Price	888-457-5770
AIG-VALIC	888-568-2542
Nationwide Retirement Solutions	800-769-4457

Allocation changes and fund transfers will be effective the same day if requested by 4 p.m. If after 4 p.m., changes will be effective the next business day.

Annual Leave and Compensatory Time Payoff

You may elect to defer your annual leave and compensatory time payoff up to the annual limits into the deferred compensation plan. To increase your contribution amount for the leave payoff check, you will need to submit an enrollment or a change form to Employee Benefits, Department of Human Resources by the last day of the month prior to the month that the leave payoff will be processed. The leave payoff must be processed within 2-1/2 months following termination of employment. If you do not submit a new form, the contribution amount taken from your leave payoff will be the amount on record for you. Amounts contributed to deferred compensation are subject to Social Security and Medicare taxes. Therefore, the deferred compensation amount taken may be lower than the requested amount due to the withholding requirement for these taxes. Contact the Deferred Compensation Help Desk for more information.

Financial Benefits Help Desk

If you have general questions about deferred compensation, you may call the Help Desk at 703-324-4995. The Help Desk is located in the Department of Human Resources and is manned five days a week by a deferred compensation provider representative from AIG-VALIC, ICMA-RC or Nationwide Retirement Solutions.

Day	Plan Representative	Hours
Monday	ICMA-RC	9:30 a.m. – 4:00 p.m.
Tuesday	AIG-VALIC	9:30 a.m. – 4:00 p.m.
Wednesday	ICMA-RC	9:30 a.m. – 4:00 p.m.
Thursday	AIG-VALIC	9:30 a.m. – 4:00 p.m.
Friday	Nationwide	9:30 a.m. – 1:30 p.m.

Flexible Spending Accounts

Benefit eligible employees have the opportunity to participate in two pre-tax flexible spending accounts: the Dependent Care Account and the Medical Spending Account. These accounts allow you to set aside funds on a pre-tax basis to reimburse yourself for eligible out-of-pocket dependent care or medical expenses. Because the dollars you place in these accounts are taken out of your pay before they are taxed, you lower your taxable income, thereby saving you money on Social Security and Medicare taxes, and state and federal income taxes.

Each year you may elect to place a designated amount of pre-tax dollars in your flexible spending account(s) for the plan year. The dollars you place in these accounts will be deducted over 24 pay periods during the calendar year. When you submit proof of an eligible expense, you will be reimbursed from your account.

Changes to your deduction amounts can only be made when there is an eligible qualifying event. You must re-enroll each year during open enrollment to continue participation for the next plan year. When re-enrolling for 2007, you do not have to complete a new direct deposit form for Fringe Benefits Management Company if you had direct deposit in 2006.

Use It or Lose It Rule: IRS rules state that if you don't use all of the money in your account within the plan year or **the new 2½ month grace period** following the plan year, those funds will no longer be available to you. It is important to be sure you don't contribute more than your projected expenses. The worksheet included in the enrollment kit will assist you in computing the amount needed to participate in the dependent care and/or medical spending accounts.

Dependent Care Account

You can elect to set aside up to $5,000 annually to pay for childcare or the care of an incapacitated spouse or other dependent (such as an elderly parent). These expenses must be necessary for you or you and your spouse to work. Daycare center charges, family daycare, summer day camp, before and after school care, pre-school and au pair expenses are examples of eligible expenses.

Medical Spending Account

You can elect to set aside up to $5,000 annually to pay for eligible out-of-pocket medical expenses by using the medical spending account. These expenses may be for yourself, your spouse and any dependents you claim for income tax purposes. You do not have to participate in a County health plan, or have your dependents enrolled in a County health plan, to use the flexible spending account. Eligible expenses include deductibles, co-payments, prescriptions, contact lenses, eyeglasses, laser vision corrective surgery, orthodontia and many over-the-counter medical/dental products. See the enrollment kit for a

Who to contact

Fringe Benefits Management Company (FBMC)
800-342-8017

County Benefits
703-324-3432

Things to know

Claims Administrator
The claims administrator is Fringe Benefits Management Company (FBMC). They can be reached at 800-342-8017 or at http://www.myfbmc.com.

Re-enroll
Every year you must re-enroll into the flexible spending programs during open enrollment for the next plan year.

When re-enrolling for 2007, you do not have to complete a new direct deposit form for FBMC if you had direct deposit in 2006.

Reimbursements
Claims will be processed daily.

detailed list of eligible expenses.

Maximum/Minimum

Dependent Care Account

$5,000 Maximum annual contribution (regardless of number of dependents)
$2,500 Maximum annual contribution for married individuals filing separately
$ 125 Minimum annual contribution

Medical Spending Account

$5,000 Maximum annual contribution
$ 125 Minimum annual contribution

Eligibility

Benefit eligible employees have 60 days from their eligibility date to enroll in the flexible spending accounts. Coverage is effective under the plan the first of the month following receipt of the enrollment form or online enrollment for flexible spending account purposes. An eligible dependent is any person considered a dependent under Section 152 of the Internal Revenue Code.

Termination of your flexible spending account

Participation in the flexible spending account(s) will terminate on the earliest of the following dates:

- the end of the month in which your employment terminates, or the end of the month in which you cease to be employed in a benefits eligible position; or
- the end of the plan year.

Upon termination of the flexible spending account, you will have a run-out period (as specified in "Run Out Periods" section) during which to submit claims for reimbursement of expenses incurred before your termination date.

Run Out periods

For active employees: You have 90 days following the plan year to submit claims that you incurred during the previous plan year or during the 2½ month grace period.

For terminated employees (including retiring employees): You have 90 days following your termination date from the plan to submit claims for expenses incurred prior to your termination date.

Reimbursements

Claims are processed daily. Employees who participate in the Medical Spending Account also have the option of using an EZ Reimburse MasterCard which is a stored-value card. It is a convenient Medical Expense Account option that allows FBMC to electronically reimburse for eligible expenses by deducting the amount from your Medical Spending election amount. See FBMC's 2007 Reference

Eligible claims must be incurred during the plan year or during the **new 2½ month grace period** following the end of the plan year. According to current IRS rules, an expense is considered incurred when service is actually received, not when you are billed or pay for the service.

The Medical Spending Account and Dependent Care Account are separate accounts. Funds cannot be transferred from one account to the other.

Guide for more detailed information concerning EZ Reimburse MasterCard.

The Medical Spending Account and Dependent Care Account are separate accounts. Funds cannot be transferred from one account to the other. Eligible claims must be incurred during the plan year or during the 2½ month grace period following the end of the plan year. According to current IRS rules, an expense is considered incurred when service is actually received, not when you are billed or pay for the service. (For special rules relating to orthodontia, see the plan materials or contact the plan administrator's customer service department.)

COBRA for the Medical Spending Account

If you are participating in the Medical Spending Account at the time of a COBRA qualifying event, you may elect to continue your coverage in that account under COBRA for the remainder of the current plan year. If the Medical Spending Account is continued under COBRA, charges incurred during the period of continued coverage are eligible for reimbursement as long as the participant continues to contribute to the Medical Spending account. Once contributions cease, participation in COBRA ends automatically.

Family status changes

When you have a qualifying change of status event that alters your coverage needs, you must submit a new election form and documentation of the family status change to the Benefits Division in the Department of Human Resources (see charts on pages 38-41). Your form must be received within 60 days from the date of the event. See pages 74-76 for specific deadline dates. Call the Benefits Division 703-324-4916 or go to the Benefits web site on the County Infoweb for a package of information on the flexible spending accounts, which includes information on allowable family status changes.

Group Term Life Insurance

Term life insurance can be an important building block in your family's foundation of financial security. Although there is no cash value from which to borrow, it gives your family a base of protection that can be supplemented by personal savings and Social Security benefits.

Each benefit eligible employee receives a basic employer-paid benefit of one times annual salary in life insurance coverage. You can choose to participate in an optional employee-paid benefit to supplement the employer provided benefit.

What benefits are available to you?

- Basic employer-paid insurance, equal to one times your annual salary rounded to the next higher $1,000, up to a maximum of $250,000. Fairfax County Government pays the total cost of basic coverage.

- Optional employee-paid insurance is paid by you through convenient payroll deductions. You can apply for one, two, three or four times your salary in additional coverage, rounded to the next higher $1,000. The lesser of two times salary or $325,000 is guaranteed to new employees if elected within 60 days of initial eligibility. After you become insured, all future increases due to increases in your salary are guaranteed up to the plan maximum of $500,000.

- Coverage amounts will be increased or decreased due to age or salary changes on the first of the month following the change.

Cost of the term life insurance

The cost of the optional plan is outlined below:

Age	Monthly Premium Rate per $1,000 of coverage
Under 30	$0.09
30-49	$0.17
50-59	$0.31
60-79	$0.49
80-84	$4.04

Benefit Example:
You are 40 years of age and have an annual salary of $50,000. You are provided Basic coverage equal to one times your salary. You elect optional coverage of two times your salary. Your total insurance coverage is $150,000 ($50,000 Basic, $100,000 Optional). Your premium is $17.00/month or $8.50 biweekly. Since the first $50,000 of optional coverage is a pre-tax benefit, your net pay is reduced by less than the biweekly cost.

What benefits are available to my family?

Additional coverage is available to insure your spouse and eligible dependent

Who to contact

For more information on term life insurance call:

703-324-3374
or 703-324-3437

Basic coverage is effective on the date of hire.

Optional coverage is effective the 1st of the month following election.

children under this program. If you apply when first eligible, you may choose coverage for your family on a guaranteed basis. You can choose between two coverage options.

Children from birth to nine days have a reduced benefit of 10 percent of the coverage amount.

Coverage Amount

Coverage	*Spouse/Child**	*Monthly Premium*
Low Option	$6,250/$2,500	$2.50
High Option	$12,500/$6,250	$5.00

*Coverage ceases at the end of the month in which an eligible dependent child reaches age 23.

Do I have accidental death and dismemberment benefits?

Yes, if you are an employee. Both the Basic and Optional programs double your life insurance amount if you die as a result of an accident. Refer to the benefit schedule in the certificate for dismemberment that results from bodily injury. This benefit terminates at retirement.

What is the accelerated death benefit?

If you become terminally ill, with life expectancy of less than 12 months, you may withdraw a portion of your death benefit or the full amount, less any charges, while you are living. There are no limitations on how you spend the money.

How to sign up for term life insurance benefits

Every benefit-eligible employee needs to designate beneficiary(ies) on the benefit election form.

Basic life insurance becomes effective on your initial benefits eligibility date. You have 60 calendar days from your initial benefits eligibility date to request guaranteed optional and dependent coverage. (See pages 74-76.)

The guaranteed optional coverage will become effective the first day of the month following the date the enrollment request is received in the Benefits Division of Human Resources. Optional coverage above the guaranteed amount will become effective the first of the month following vendor approval. If you do not enroll within the initial 60-day period, you may apply for the additional optional coverage during the next open enrollment, but it is not guaranteed.

You have 60 calendar days from your date of employment or eligibility to request guaranteed optional and dependent coverage.

New hires must enroll by the 60th calendar day. (See pages 74-76.)

Coverage reduces to 65 percent of the original amount at age 65, or retirement, whichever occurs first.

It reduces again to 30 percent of the original amount at age 70.

Benefit reduction schedule

- Coverage reduces to 65 percent of the original amount on the first of the month after you turn 65 or retire, whichever occurs first.
- It reduces again to 30 percent of the original amount on the first of the month after you turn 70.

Coverage termination

If you terminate your employment, your coverage will continue until the end of the month in which you terminate. You may elect to convert your coverage and any family coverage you have to individual whole life policies on a guaranteed basis within 31 days of coverage termination. Call 703-324-3437 for the conversion form.

What changes can you make during open enrollment?

- You may decrease or cancel your Optional coverage.
- You may apply for Optional coverage (one, two, three, or four times your salary). The increase in Optional coverage will be contingent upon approval by Minnesota Life.
- You may apply for dependent coverage. Requested dependent coverage will be contingent upon approval by Minnesota Life.

The necessary forms can be obtained from your agency payroll contact, from the Benefits Division in the Department of Human Resources, Suite 270, Government Center, or the Benefits web site on the County Infoweb or though http://www.fairfaxcountybenefits.benelogic.com

What changes can you make outside open enrollment?

- Add dependent coverage within 60 days of a qualifying event.
- Cancel dependent coverage at anytime.
- Reduce Optional coverage if the reduction would result in optional coverage of at least $50,000 still in place.
- Change beneficiary(ies).

Long-term disability salary insurance

Who to contact

For more information on long-term disability salary insurance call:

CIGNA LTD
Customer Service
800-238-2125

County information line
703-324-3437

The County offers a voluntary group long-term disability insurance plan which provides a monthly benefit in the event of an accident or illness that makes you unable to work for an extended period.

The amount of the benefit depends upon the employee's salary and the extent to which other sources of disability income are utilized. The plan pays a benefit of up to 60 percent of an employee's monthly basic earnings – to a maximum of $3500. Your benefit amount is reduced by any amounts payable to you by any of the sources listed in the detailed enrollment brochure. For example, the long-term disability benefit will be reduced by Social Security retirement and/or disability benefits payable to you. However, your benefits from this plan will never be less than $100 per month or 10% of the eligible benefit prior to reductions for other income benefits, whichever is greater. Since the deductions are taken post tax, you will not pay taxes on the monthly benefit.

Special Enrollment Opportunity

For this open enrollment period only (October 16 through November 17, 2006), CIGNA has removed the medical evidence of insurability requirement, allowing employees to enroll without proof of good health. Employees who take advantage of this special enrollment period will have their coverage effective January 1, 2007. To enroll, simply go to the Benelogic website (see page 15) and elect the LTD coverage.

Enrolling after the special enrollment opportunity

New hires who enroll through www.fairfaxcountybenefits.benelogic.com or who submit enrollment forms to the Benefits Division in the Department of Human Resources within 60 days from date of hire or eligibility are guaranteed coverage. See pages 74-76 for specific deadline dates. You may apply at any time, but after the initial 60-day enrollment period, you will need to complete an evidence of insurability form and be approved by CIGNA for this coverage. The insurance will become effective the first of the calendar month following the date you elect this coverage, provided you make your election within the first 60 days of employment or benefits eligibility. If you apply after your first 60 days of employment, your effective date (if approved) will be determined by CIGNA, the administrator of the County's long-term disability plan.

Benefit waiting period

Before collecting benefits, you must satisfy a 90-day benefit waiting period. Hence, benefits are payable on the 91st day of disability.

Limitations

Please see the detailed brochure for language pertaining to preexisting conditions, limitations to Mental/Nervous Conditions and Drug/Alcohol Abuse and exclusions.

Conversion

If you are terminating from County employment and have had long-term disability insurance for at least 12 consecutive months, you are eligible to convert to Disability Conversion Insurance. You have 31 days from date of termination to submit an application without evidence of good health. If you apply for the new coverage after 31 days but not more than 62 days after your termination of employment date, you will be required to supply evidence of insurability.

Premiums

The premiums are based on age and salary. The 2007 premiums are lower than our current rates. However, some employees currently in the plan may see a marginal increase because of the higher plan maximum. To calculate the cost of your coverage, follow these steps:

Divide your annual salary by 12. If the amount is over $5833, enter $5833 on the line. _____

Enter the rate for your age group. (See the rate chart below.) _____

Multiply gross pay (line 1) by the rate for your age group. _____

Divide by 100 to determine the monthly premium. _____

Divide by 2 to determine the biweekly deduction. _____

Age Band	Rates
Under 25	.12
25-29	.14
30-34	.16
35-39	.19
40-44	.36
45-49	.54
50-54	.74
55-59	.80
60-64	.82
65+	.91

For example, a 40 year old employee earning $3,500 per month would have a biweekly deduction of $6.30. ($3,500 x .36=$1,260, $1,260/$100= $12.60, 12.60/2 = $6.30) This employee would be eligible for up to $2,100 per month after the elimination period and preexisting condition requirements have been met.

Long-term Care Insurance

Who to contact

Aetna
800-537-8521
www/aetna.com/group/fairfaxcounty

County Benefits
703-324-4915
703-324-4916
703-324-3437

Long-term care refers to services you may need if you become unable to care for yourself. This plan provides a daily benefit when you are unable to perform at least two of six activities of daily living: bathing, dressing, eating, transferring, toileting, and continence or when you have a severe cognitive impairment such as Alzheimer's disease. Your benefits begin after a single 90-day waiting period. You choose where you want care: at home, an assisted living facility, nursing home, adult day care and hospice.

Detailed information on the plan is available in the Outline of Coverage Booklet included in the Enrollment Kit. The following information provides a brief overview of the plan.

Eligibility

You are guaranteed the coverage if you enroll within 60 days of benefit eligibility. If you apply after your initial eligibility period, you will need to complete an enrollment form and a medical questionnaire. Coverage for late enrollees will require plan approval.

Retirees, spouses of employees and retirees, surviving spouses of retirees, adult children of employees or retirees, as well as parents or parents-in-law, grandparents or grandparents-in-law of employees may apply for the coverage at anytime. Applicants will need to complete an enrollment form and a medical questionnaire and be approved by Aetna.

How and when to enroll

You may enroll online at *www.aetna.com/group/fairfaxCounty* if you apply within 60 days of benefit eligibility. You are guaranteed coverage if you apply within 60 days. Retirees and family members can download forms from Aetna's website or call the Aetna hotline at 800-537-8521 for enrollment kits. Completed enrollment and medical questionnaire forms (if applicable) should be returned directly to Aetna. After processing your enrollment, Aetna will mail the insured a certificate of coverage booklet.

Effective date

The effective date for newly eligible participants is the first of the month following receipt of application. Late entrants become effective the first of the month following approval by Aetna.

Long-term care plan design

You can choose from three core plans or you can customize your own plan. Key components of each plan are described below:

Benefit/Feature	Plan A	Plan B	Plan C	Customized
Daily Benefit Amount (DBA)	$100	$200	$250	$100, $150, $200, $250
Lifetime Maximum Pool of Money*	$109,500 (3 years)	$219,000 (3 years)	$456,250 (5 years)	$109,500 to $456,250 (3 or 5 years)
Home Care and Community Care	50% of DBA	50% of DBA	75% of DBA	50% or 75% of DBA
Inflation Protection	Voluntary: 5% compounded every 3 years	Voluntary: 5% compounded every 3 years	Voluntary: 5% compounded every 3 years	Voluntary: $1 increments Up to 5% of the plan maximum compounded every 3 years Automatic: 5% of your current DBA annually.
Benefits Bank (If premium payments are stopped after 3 years, you may have a benefit if you go into claim status.)	No	No	Yes	Optional
Return of Contribution (Premiums may be returned to your beneficiary upon your death.)	No	No	Yes	Optional
Limited Pay (Premiums are paid up at age 65 or 10 years, whichever is greater.)	No	No	No	Optional

* Based on when and where you receive care, your lifetime maximum benefit could be paid out in a minimum of 3 or 5 years. If your daily services cost less than your daily benefit amount or you do not need to receive services every day, your benefits will last longer than your benefit period. For example, if you choose a 3-year plan with a DBA of $300 and then receive covered services reimbursed at $150 a day, your pool of money would be exhausted in six years.

Covered expenses

If you become eligible for benefits, the plan will reimburse you for bills submitted for covered expenses up to your Daily Benefit Amount (DBA), or a percentage of your DBA as indicated below:

Nursing Home or Hospice Facility Care	Actual Expenses up to 100% of DBA
Assisted Living Facility Care	Actual Expenses up to 100% of DBA
Adult Day Care:	Actual Expenses up to 50% or 75% of DBA
Community-Based Hospice Care	Actual expenses up to 50% or 75% of DBA
Home Health Care	Actual expenses up to 50% or 75% of DBA
Community Based Care	Actual expenses up to 50% or 75% of DBA
Alternate Care	Actual Expenses up to 50% or 75% of DBA
Bed Reservation	100% of DBA for 21 days per calendar year

Additional benefits that **do not** reduce your lifetime maximum are noted below:

Transitional Care	One time payment equal to 3 times the DBA
Informal Care	25% of the DBA for up to 50 days per calendar year
Informal Caregiver Training	One payment per claim period equal to cost of training up to 3 times the DBA
Respite Care	50% of the DBA for up to 21 days per calendar year.

Premiums

The premium for long-term care coverage will vary depending upon the covered person's age at the time of application and the choice of benefit options. The premium rate tables are in the Outline of Coverage Booklet included in the Enrollment kit. Premium rates for all plan options can be computed on the online calculator at Aetna's website for our group plan. A covered person may choose between the following premium payment options: payment over the entire term of coverage or payment to the later of age 65 or a 10 year period.

The County makes no contribution toward the cost of long-term care insurance. Employees will have payroll deductions for themselves and their spouses. All others will be directly billed by Aetna. The plan waives the premium when the insured is receiving benefits. In addition, the plan has a 30-day free look provision. This means the premiums will be refunded if you cancel your plan within 30 days of receiving the certificate of coverage booklet.

Sample Comparison of Monthly Premium Rates
(refer to website for complete list)

Age	Plan A	Plan B	Plan C
45	$14.30	$ 28.60	$ 56.25
47	$16.20	$ 32.40	$ 62.50
52	$22.40	$ 44.80	$ 84.50
58	$37.90	$ 75.80	$138.00
63	$60.80	$121.60	$212.50

Plan changes and cancellations

You may increase your coverage at anytime with plan approval. You may also elect to cancel your coverage or decrease your coverage at anytime. Call Aetna's hotline at 800-537-8521 for assistance with your change and cancellation requests. Aetna will notify the County of plan and premium changes.

Continuation of coverage

When you leave the County, you can continue your coverage at the same group rate by paying premiums directly to Aetna.

Virginia College Savings Plans

Employees have the opportunity to participate in three Section 529 college tuition savings plans offered by the Commonwealth of Virginia: the Virginia Prepaid Education Program (VPEP), the Virginia Education Savings Trust (VEST), and CollegeAmerica. Each plan provides significant tax advantages: (1) earnings grow tax free, (2) withdrawals for college expenses are tax free and (3) residents of Virginia can deduct the entire investment, over time, on their Virginia tax returns. A brief description of each plan follows:

- **VPEP** locks in future college costs for today's students in the ninth grade or younger. Contract payments are invested so that their steady growth will cover full tuition and mandatory fees at Virginia public colleges and universities. This plan has a guaranteed rate of return for other types of colleges nationwide.

- **VEST** offers 12 no-load investment options, which include four Vanguard mutual funds. Students of all ages can participate wherever they live. You can use VEST to pay for all major college expenses. These include tuition, fees, room and board, textbooks, required computers and supplies.

- **CollegeAmerica** gives investors a choice of 21 American funds in four share classes, including one for employer-sponsored programs with significantly lower fund management fees. You can use CollegeAmerica assets to pay for tuition, fees, room and board, textbooks, required computers and supplies.

Contributions are made directly to the Commonwealth of Virginia. Payroll deductions are not possible.

Who to contact

VPEP and VEST
888-567-0540
www.Virginia529.com

CollegeAmerica
703-324-4995

Enrollment period

VPEP has a limited enrollment period each year. VPEP's enrollment period will be held from December 1, 2006 through February 28, 2007. VEST and CollegeAmerica are open all year.

Plan information

VPEP and VEST enrollment kits and forms are available from DHR as well as the Virginia College Savings Plan. Employees with specific questions on VPEP or VEST are encouraged to call the Virginia College Savings Plan at 888-567-0540 or visit their website at www.Virginia529.com. Employees interested in the College America Plan may call the Financial Benefits Help Desk at 703-324-4995, TTY 703-222-7314.

Fees

The County has agreed to sponsor the Virginia College Savings Plan to provide employees with significant savings on investment fund expenses in CollegeAmerica. To qualify for the lower fees, employees must use the automatic payment authorization forms noting the County's group number and agree to automatic debits from a checking or savings account. The CollegeAmerica forms with the County group number are available from the Financial Benefits Help Desk.

APPENDIX 1- HIPAA Privacy Rules
PROTECTION OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Section 1 -- GENERAL

Section 1.1 Limited Applicability. This Appendix 1 is for the sole and limited purpose of complying with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR § 164.102 *et seq.*, as amended from time to time, and any successor thereto (the "Privacy Rule"). This Appendix 1 shall not affect, or be taken into account in determining the benefits under the Plan with respect to any individual. To the extent that any of these provisions are no longer required, they shall be deemed deleted and shall have no further force or effect.

Section 1.2 Interpretation. This Appendix 1 is intended to comply with the Privacy Rule and shall be construed in a manner that will effectuate this purpose. This Appendix 1 shall not be construed in a manner that is inconsistent with the stated purpose.

Section 1.3 Effective Date. The effective date of this Appendix 1 is April 14, 2003.

Section 2 -- DEFINITIONS

Section 2.1 General. For purposes of this Appendix 1, the following terms shall have the meanings given to them below. To the extent not defined for purposes of this Appendix 1, capitalized terms shall have the meanings given to them in the Plan.

"De-identified Information" shall be defined as individually identifiable health information that has been de-identified in accordance with the requirements of 45 CFR § 164.514(b), or any successor thereto. De-identified Information is not subject to the Privacy Rule.

"Health Maintenance Organization" shall be defined as it is in 45 CFR § 160.103, or any successor thereto.

"Health Insurance Issuer" shall be defined as it is in 45 CFR § 160.103, or any successor thereto.
"PHI" shall be defined as it is in 45 CFR § 164.501, or any successor thereto.

"Participation and Enrollment Information" shall be defined as the information described in 45 CFR § 164.504(f)(1)(iii), or any successor thereto.

"Plan" consists of employee welfare beneft plans related to health care, medical flexible spending accounts, lon-term care insurance, and dental insurance.

"Plan Administration Functions" shall be defined as those activities, and only those activities, that both (i) meet the definition of "payment" or "health care operations" under 45 CFR § 164.501, or any successor thereto, and (ii) are listed in Section 5.1 hereof.

"Plan Sponsor" shall be defined as it is Section 3.1 hereof.

"Privacy Official" shall be defined as it is in Section 4.1 hereof.

"Settlor Functions" shall be defined as the functions described in 45 CFR § 164.504(f)(1)(ii)(A) and (B), or any successor thereto.

"Summary Health Information" shall be defined as it is in 45 CFR § 164.504(a), or any successor thereto.

Section 3 -- PLAN SPONSOR

Section 3.1 Identity of Plan Sponsor.

a. The County shall be the Plan Sponsor for purposes of the Privacy Rule when performing Plan Administration Functions or Settlor Functions, when acting on behalf of the Plan with respect to its obligations under the Privacy Rule, and when acting on behalf of the Plan's participants and beneficiaries with respect to Participation and Enrollment Information.

b. The Chief, Benefits Division of the Department of Human Resources shall act for the Plan Sponsor, and shall be entitled to delegate its powers and responsibilities in accordance with its usual practices.

c. Individuals and classes of individuals identified in Section 5.2 hereof shall be considered part of the Plan Sponsor.

Section 3.2 -- Responsibilities and Undertakings.

a. The Plan Sponsor shall be responsible for making any necessary certifications to the Plan. Such certifications shall be delivered to the Plan's Privacy Official.

b. The Plan Sponsor also undertakes and agrees that it:

(i) Shall not use or disclose PHI except as specified in Section 5 of this Appendix 1.

(ii) Shall require any agents or subcontractors to whom it discloses PHI to agree to the same restrictions on the use and disclosure of PHI as apply to the Plan Sponsor;

(iii) Shall not use or disclose PHI for any employment-related actions of the County;

(iv) Shall not use or disclose PHI in connection with any other benefits or benefit plan, program, or arrangement of the County (except to the extent that such other benefits, or benefit plan, program, or arrangement is part of an organized health care arrangement of which the Plan also is a part).

(v) Shall report to the Privacy Official any uses or disclosures of PHI inconsistent with the terms of this Appendix 1 of which it becomes aware.

(vi) Shall make PHI available in accordance with an individual's right of access in accordance with the Plan's Privacy Rule policies and procedures.

(vii) Shall make PHI available for amendment and shall incorporate amendments in accordance with the Plan's Privacy Rule policies and procedures of the Plan.

(viii) Shall make information available to provide any required accounting of disclosures of PHI in accordance with the Plan's Privacy Rule policies and procedures.

(ix) Shall make available to the Secretary of Health and Human Services its internal practices, books, and records relating to the use and disclosure of PHI from the Plan for purposes of determining the Plan's compliance with the Privacy Rule.

(x) Shall, if feasible, return to the Plan or destroy any PHI from the Plan that it maintains in any form, and shall retain no copies of the PHI when the PHI is no longer needed for the purpose for which disclosure was originally made. If it is not feasible to return or destroy the PHI, the Plan Sponsor agrees that it shall further limit any uses and disclosures to those purposes that make the return or the destruction of the information not feasible.

(xi) Shall ensure that adequate separation between the Plan Sponsor and the Plan is established.

Section 4 -- PRIVACY OFFICIAL

Section 4.1 Identity of Privacy Official. The Privacy Official shall be the Fairfax County HIPAA Compliance Manager.

Section 4.2 Power and Authority of the Privacy Official. The Privacy Official shall be entitled to delegate its powers and responsibilities in accordance with its usual practices.

Section 4.3 Responsibilities of the Privacy Official. The Privacy Official shall have the duties and responsibilities specified in the law. Such duties and responsibilities shall include accepting and verifying the accuracy and completeness of any certification provided by the Plan Sponsor with respect to disclosures and uses of PHI, and transmitting the certification to any Health Insurance Issuers or Health Maintenance Organizations with respect to the Plan in order to permit them to disclose information to the Plan Sponsor based on such certification.

Section 5 -- USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Section 5.1 Permitted Uses and Disclosures of PHI

a. Certification. The Plan, and any Health Insurance Issuer or Health Maintenance Organization with respect to the Plan, may disclose PHI to the Plan Sponsor only following receipt by the Plan, and any Health Insurance Issuer or Health Maintenance Organization with respect to the Plan, of the Plan Sponsor's certification that the Plan has been amended in accordance with the requirements of the Privacy Rule.

b. Plan Administration. The following uses and disclosures of PHI by the Plan Sponsor for purposes of plan administration are permitted provided they are consistent with 45 CFR § 164.502(a)(1)(ii) or (iii), and any successors thereto:
   (i) Disclosures necessary to adjudicate appeal of denied claims (including disclosures to any necessary external experts in accordance with the Plan's claims review procedures).
   (ii) Disclosures necessary to provide assistance to participants and beneficiaries in the claims process (*i.e.*, claims advocacy).
   (iii) Disclosures necessary to provide information for purposes of selecting and contracting with service providers to the Plan.

c. Compliance with Privacy Rule. The following uses and disclosures of PHI by the Plan Sponsor for purposes of complying with the Privacy Rule are permitted to the extent necessary for compliance.
   (i) Uses and disclosures required under 45 CFR § 164.502(a)(2)(i) and (ii), or any successors thereto.
   (ii) Uses and disclosures permitted without permission from an individual under the following provisions of the Privacy Rule, or any successors thereto:
      (A) 45 CFR § 164.502(a)(1)(i) (to the individual);
      (B) 45 CFR § 164.512 (specified uses and disclosures);
      (C) 45 CFR § 164.504(e) (disclosures to Business Associates);
      (D) 45 CFR § 164.502(a)(1)(iii) (incidental disclosures).
   (iii) Uses and disclosures permitted only with explicit or implicit authorization under 45 CFR § 164.508 or 45 CFR § 164.510, or any successors thereto.
   (iv) Uses and disclosures permitted because the PHI has been cleansed. Under the following provisions of the Privacy Rule, or any successors thereto:
      (A) 45 CFR § 164.514(b) (de-identified information);
      (B) 45 CFR § 164.514(e) (limited data sets).

d. Participation and Enrollment Information. Participation and Enrollment Information may be disclosed as necessary to the Plan Sponsor.

e. Summary Health Information. Summary Health Information may be disclosed to the Plan Sponsor for the limited purpose of performing Settlor Functions.

f. De-Identified Information. De-Identified Information is not subject to the Privacy Rule and may be disclosed to the Plan Sponsor at any time.

Section 5.2 -- Individuals With Access to PHI

a. For purposes of the Privacy Rule, the following individuals or groups of individuals are under the direct control of the Plan Sponsor, will be treated as the workforce of the Plan Sponsor, and are permitted to have access to PHI disclosed by the Plan or any Health Insurance Issuer or Health Maintenance Organization for the purposes specified.
   (i) Members of the Employee Benefits Division of the Department of Human Resources for all purposes relating to the administration of the Plan.
   (ii) Members of the Payroll Division of the Department of Human Resources for premium payment responsibilities.
   (iii) Members of the Employee Relations Division of the Department of Human Resources for all purposes relating to the administration of the Employee Assistance Program.

b. Any characterization of an individual as being under the direct control of the Plan Sponsor is exclusively for the purpose of the Privacy Rule and has no other significance. Such characterization for purposes of the Privacy Rule does not, for example, create any employment relationship or result in any entitlement to benefits under this Plan or any other benefit plan, scheme, or arrangement of the County.

c. The Privacy Official and his or her delegates, if any, are permitted to have access to PHI disclosed by the Plan and any Health Insurance Issuer or Health Maintenance Organization with respect to the Plan.

Section 5.3 -- Limitations on Disclosures of, Access to, and Uses of PHI. PHI may be disclosed from the Plan only for Plan Administration Functions performed on behalf of the Plan, and the other purposes listed in Section 5.1, above. Any employees or other persons listed in Section 5.2 hereof shall have access to PHI only to perform Plan Administration Functions, and other functions listed in Section 5.1, above, on behalf of the Plan.

Section 6 -- NONCOMPLIANCE WITH ESTABLISHED LIMITATIONS ON ACCESS, DISCLOSURE, AND USE OF PHI

Section 6.1 Noncompliance. If the Plan Sponsor becomes aware of the fact that an employee or other individual listed in Section 5.2 hereof has failed to comply with the access or use limitations on PHI described in Section 5.1 hereof, the Plan Sponsor shall inform the Privacy Official and the Privacy Official shall determine in accordance with the Plan's Privacy Rule policies and procedures, what sanctions, if any, should be imposed.

FAIRFAX COUNTY GOVERNMENT HEALTH PLAN
and its affiliated entities

NOTICE OF PRIVACY PRACTICES

EFFECTIVE April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

The following entities, affiliated with FAIRFAX COUNTY GOVERNMENT, are covered by this notice:

This notice applies to the privacy practices of the health plans listed below. As affiliated (related) entities, we may share your protected health information and the protected health information of others on your insurance policy as needed for payment or health care operations.

CareFirst BlueCross BlueShield
BlueChoice POS
BluePreferred PPO
Kaiser Permanente
CIGNA HealthCare
Delta Dental PPO
AETNA (Long Term Care)
FBMC (Medical Spending Account)
INOVA (Employee Assistance Program)

Our Legal Duty

This Notice describes our privacy practices, which include how we might use, disclose (share or give out), collect, handle, and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and is not intended to amend any prior notice of Fairfax County Government Health Plan privacy practices.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as law permits these changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers within sixty days of the effective date of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Medical Information
Primary Uses and Disclosures of Protected Health Information

We use and disclose protected health information about you for payment and health care operations. The federal health care privacy regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, state privacy laws, or other federal laws, rather than the federal HIPAA (Health Insurance Portability and Accountability Act) privacy regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, and reproductive rights. In addition to these state law requirements, we also may use or disclose protected health information in the following situations:

Payment: We may use and disclose your protected health information for all activities that are included within the definition of "payment" as written in the federal privacy regulations. For example, we might use and disclose your protected health information to pay claims for services provided to you by doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan. We might also use your information to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations: We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as defined in the federal privacy regulations. For example, we might use and disclose your protected health information to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, and to manage our business.

Business Associates: In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, our business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

Other Covered Entities. In addition, we may use or disclose your protected health information to assist health care providers in connection with *their* treatment or payment activities, or to assist other covered entities in connection with certain of *their* health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the area of quality assurance and improvement activities or accreditation, certification, licensing or credentialing.

Other Possible Uses and Disclosures of Protected Health Information

The following is a description of other possible ways in which we might (and are permitted to) use and/or disclose your protected health information.

To You or with Your Authorization: We must disclose your protected health information to you, as described in the Individual Rights section of this notice. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed on this notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures that we made as permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your protected health information for any reason except those described in this notice.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the federal privacy regulations.

To Plan Sponsors: Where permitted by law, we may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us seeking information to evaluate future changes to your benefit plan. We also may disclose summary health information (this type of information is defined in the federal privacy regulations) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered though your group health plan or to decide whether to modify, amend or terminate your group health plan.

To Family and Friends: If you agree (or, if you are unavailable to agree, such as in a medical emergency situation), we may disclose your protected health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

Underwriting: We may receive your protected health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this protected health information received under these circumstances for any other purpose, except as required by law, unless and until you enter into a contract of health insurance or health benefits with us.

Health Oversight Activities: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i.) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Abuse or Neglect: We may disclose your protected health information to appropriate authorities if we reasonably believe that you may be a possible victim of abuse, neglect, domestic violence or other crimes.

To Prevent a Serious Threat to Health or Safety: Consistent with certain federal or state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Coroners, Medical Examiners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for purposes of identifying you after you die, determining your cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose, as authorized by law, information to funeral directors so they may carry out their duties on your behalf. Further, we might disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

Research: We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

Inmates: If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health or safety or the health or safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation: We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Public Health and Safety: We may use or disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon their request for purposes of determining whether we are in compliance with federal privacy laws.

Legal Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose to a law enforcement official limited protected health information of a suspect, fugitive, material witness, crime victim, or missing person. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Military and National Security: We may disclose to military authorities the protected health information of Armed Forces personnel under certain circumstances. We may disclose to federal officials protected health information required for lawful intelligence, counterintelligence, and other national security activities.

Other Uses and Disclosures of Your Protected Health Information: Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we have already used or disclosed in reliance on your authorization.

Individual Rights

Access: You have the right to look at or get copies of your protected health information contained in a designated record set, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. You must make a request in writing to obtain access to your protected health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You also may request access by sending a letter to the address at the end of this notice. If you request copies, we might charge you a reasonable fee for each page, and postage if you want the copies mailed to you. If you request an alternative format, we might charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information, but we may charge a fee to do so.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable. If you are denied access to your information and the denial is subject to review, you may request that the denial be reviewed. A licensed health care professional chosen by us will review the request and the denial. The person performing this review will not be the same person who denied your initial request.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities, after April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we might charge you a reasonable, cost-based fee for responding to these additional requests.

You may request an accounting by submitting your request in writing using the information listed at the end of this notice. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement that we might make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be liable for uses and disclosures made outside of the requested restriction unless our agreement to restrict is in writing. We are permitted to end our agreement to the requested restriction by notifying you in writing.

You may request a restriction by writing to us using the information listed at the end of this notice. In your request tell us: (1) the information of which you want to limit our use and disclosure; and (2) how you want to limit our use and/or disclosure of the information.

Confidential Communication: If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information. This means that you may request that we send you information by alternative means, or to an alternate location. We must accommodate your request if: it is reasonable, specifies the alternative means or alternate location, and specifies how payment issues (premiums and claims) will be handled. You may request a Confidential Communication by writing to us using the information listed at the end of this notice.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: Even if you agree to receive this notice on our web site, or by electronic mail (e-mail), you are entitled to receive a paper copy as well. Please contact us using the information listed at the end of this notice to obtain this notice in written form. If the e-mail transmission has failed, and we are aware of the failure, then we will provide a paper copy of this notice to you.

Questions and Complaints

Information on Fairfax County Government's Health Plan's Privacy Practices: If you want more information about our privacy practices or have questions or concerns, you may call the member service number on the back of your insurance card or you may contact us at the address below.

Filing a Complaint: If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your individual rights, you may use the contact information at the end of this notice to complain to us. You may also submit a written complaint to the U.S. Department of Health and Human Services (DHHS) at the address below.

We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services

Contact Information

HIPAA Contact
Fairfax County Department of Human Resources, Benefits Division
12000 Government Center Parkway, Suite 270
Fairfax, VA 22035
703-324-4917

Fairfax County HIPAA Compliance Manager
Fairfax County Government Center
12000 Government Center Parkway, Suite 527
Fairfax, VA 22035
703-324-4136 -- TTY 703-968-0217
http://www.fairfaxcounty.gov/hipaa/privacy_office_officer.asp

Region III, Office for Civil Rights
U.S. Department of Health and Human Services
150 S. Independence Mall West, Suite 372
Public Leger Building
Philadelphia, PA 19106-9111
215-861-4441 -- Hotline 800-368-1019
FAX: 215-861-4431 -- TDD 215-861-4440

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under the Fairfax County Employee's health and/or dental plan (the Plan). This notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is: Chief, Benefits Division, Department of Human Resources, 12000 Government Center Parkway, Suite 270, Fairfax VA 22035. 703-324-4917. The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the qualifying events happens:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason other than his or her gross misconduct;

(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced;

(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

(5) The parents become divorced or legally separated; or

(6) The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction in hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: COBRA Administrator, Benefits Division, Department of Human Resources, 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035. If the qualifying event is a divorce, a copy of the first and last page of the divorce decree (showing the parties involved and the effective date of the divorce) must be attached. For legal separations, a notarized separation agreement signed by both parties must be attached. If a child is losing their status as a dependent before age 23, a completed "Dependent Certification Form" must be attached.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of an employee's hours of employment, COBRA continuation coverage last for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to: COBRA Administrator, Benefits Division, Department of Human Resources, 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035. A copy of the Social Security Administration's disability determination letter must be attached.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying events within 60 days of the second qualifying event. This notice must be sent to: COBRA Administrator, Benefits Division, Department of Human Resources, 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035. If the qualifying event is a divorce, a copy of the first and last page of the divorce decree (showing the parties involved and the effective date of the divorce) must be attached. For legal separations, a notarized separation agreement signed by both parties must be attached. If a child is losing his or her status as a dependent before age 23, a completed "Dependent Certification Form" must be attached. If the former employee has enrolled in Medicare, a copy of the former employee's Medicare card must be attached.**

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact: COBRA Administrator, Benefits Division, Department of Human Resources, 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035 or call 703-324-4917. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's

Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa.**

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

NOTICE OF CREDITABLE COVERAGE FOR MEDICARE-ELIGIBLE ACTIVE FAIRFAX COUNTY EMPLOYEES/DEPENDENTS

Important Notice from Fairfax County Government About Your Prescription Drug Coverage and Medicare

Read this notice carefully and keep it where you can find it. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may need to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

This notice has information about your current prescription drug coverage with Fairfax County Government and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. If you (or a dependent on your policy) are not currently eligible for Medicare, this information is not relevant for you at this time.

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Fairfax County Government has determined that the prescription drug coverage offered by the health plans provided by the BlueChoice POS, BluePreferred PPO, Kaiser Permanente and CIGNA Open Access Plus Plans are each, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

People with Medicare can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries with Medicare who are leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Fairfax County Government health plan coverage (which includes prescription drug coverage), be aware that, under current Federal rules, you and your dependents will not be able to re-enroll in this coverage until the 2007 open enrollment period for coverage beginning on January 1, 2008, unless you become eligible to re-enroll in your County health coverage due to a qualifying change in circumstances (see the Benefits Summary Handbook for more information).

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

You have the following options regarding your health and prescription drug coverages:

- Keep your current Fairfax County Government health plan coverage (which includes prescription drug coverage) and don't enroll in Medicare Part D coverage; or
- Opt out of your current Fairfax County Government health plan coverage (which includes prescription drug coverage) and enroll in Medicare Part D coverage. (Remember: you will not be able to get your County coverage back until January 1, 2008 if you opt out of it, unless you become eligible to re-enroll in your County health coverage due to a qualifying change in circumstances (see the Benefits Handbook for more information).
- You also have the option of keeping your current Fairfax County Government health plan coverage and enrolling in Medicare Part D coverage as supplemental prescription drug coverage to your current coverage, but you will have to pay premiums for both plans and may not need both types of coverage. You should be certain that you truly need both types of coverage to meet your prescription drug needs before you choose this option. If you choose to maintain both types of coverage, the primary and secondary payer status of the County's plan and Medicare Part D will be determined in the same way as it is for Medicare Parts A and B.

Remember: Your current County health coverage pays for other health expenses, in addition to prescription drugs, and you **will not** be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan and drop your health coverage with the County.

You should also know that if you drop or lose your coverage with Fairfax County Government and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact HR Central at 703-324-3311 for further information or, for more information about your County prescription drug coverage, call CareFirst Blue Cross Blue Shield (for the BlueChoice POS or BluePreferred PPO Plans) at 1-800-296-0724, Kaiser Permanente at 1-800-777-7902 or CIGNA at 1-800-244-6224.

NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Fairfax County Government changes. Additionally, you may request a copy at any time.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. Individuals enrolled in Medicare will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can get more information about Medicare prescription drug plans from the following sources:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may need to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

EMPLOYEE BENEFITS
DEADLINE DATES

DATE OF HIRE	60TH DAY OF EMPLOYMENT
JANUARY	
1/1/2007	3/1/2007
1/2/2007	3/2/2007
1/3/2007	3/3/2007
1/4/2007	3/4/2007
1/5/2007	3/5/2007
1/6/2007	3/6/2007
1/7/2007	3/7/2007
1/8/2007	3/8/2007
1/9/2007	3/9/2007
1/10/2007	3/10/2007
1/11/2007	3/11/2007
1/12/2007	3/12/2007
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1/24/2007	3/24/2007
1/25/2007	3/25/2007
1/26/2007	3/26/2007
1/27/2007	3/27/2007
1/28/2007	3/28/2007
1/29/2007	3/29/2007
1/30/2007	3/30/2007
1/31/2007	3/31/2007

DATE OF HIRE	60TH DAY OF EMPLOYMENT
FEBRUARY	
2/1/2007	4/1/2007
2/2/2007	4/2/2007
2/3/2007	4/3/2007
2/4/2007	4/4/2007
2/5/2007	4/5/2007
2/6/2007	4/6/2007
2/7/2007	4/7/2007
2/8/2007	4/8/2007
2/9/2007	4/9/2007
2/10/2007	4/10/2007
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2/25/2007	4/25/2007
2/26/2007	4/26/2007
2/27/2007	4/27/2007
2/28/2007	4/28/2007

DATE OF HIRE	60TH DAY OF EMPLOYMENT
MARCH	
3/1/2007	4/29/2007
3/2/2007	4/30/2007
3/3/2007	5/1/2007
3/4/2007	5/2/2007
3/5/2007	5/3/2007
3/6/2007	5/4/2007
3/7/2007	5/5/2007
3/8/2007	5/6/2007
3/9/2007	5/7/2007
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3/28/2007	5/26/2007
3/29/2007	5/27/2007
3/30/2007	5/28/2007
3/31/2007	5/29/2007

DATE OF HIRE	60TH DAY OF EMPLOYMENT
APRIL	
4/1/2007	5/30/2007
4/2/2007	5/31/2007
4/3/2007	6/1/2007
4/4/2007	6/2/2007
4/5/2007	6/3/2007
4/6/2007	6/4/2007
4/7/2007	6/5/2007
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4/26/2007	6/24/2007
4/27/2007	6/25/2007
4/28/2007	6/26/2007
4/29/2007	6/27/2007
4/30/2007	6/28/2007

EMPLOYEE BENEFITS
DEADLINE DATES

DATE OF HIRE	60TH DAY OF EMPLOYMENT
MAY	
5/1/2007	6/29/2007
5/2/2007	6/30/2007
5/3/2007	7/1/2007
5/4/2007	7/2/2007
5/5/2007	7/3/2007
5/6/2007	7/4/2007
5/7/2007	7/5/2007
5/8/2007	7/6/2007
5/9/2007	7/7/2007
5/10/2007	7/8/2007
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5/20/2007	7/18/2007
5/21/2007	7/19/2007
5/22/2007	7/20/2007
5/23/2007	7/21/2007
5/24/2007	7/22/2007
5/25/2007	7/23/2007
5/26/2007	7/24/2007
5/27/2007	7/25/2007
5/28/2007	7/26/2007
5/29/2007	7/27/2007
5/30/2007	7/28/2007
5/31/2007	7/29/2007

DATE OF HIRE	60TH DAY OF EMPLOYMENT
JUNE	
6/1/2007	7/30/2007
6/2/2007	7/31/2007
6/3/2007	8/1/2007
6/4/2007	8/2/2007
6/5/2007	8/3/2007
6/6/2007	8/4/2007
6/7/2007	8/5/2007
6/8/2007	8/6/2007
6/9/2007	8/7/2007
6/10/2007	8/8/2007
6/11/2007	8/9/2007
6/12/2007	8/10/2007
6/13/2007	8/11/2007
6/14/2007	8/12/2007
6/15/2007	8/13/2007
6/16/2007	8/14/2007
6/17/2007	8/15/2007
6/18/2007	8/16/2007
6/19/2007	8/17/2007
6/20/2007	8/18/2007
6/21/2007	8/19/2007
6/22/2007	8/20/2007
6/23/2007	8/21/2007
6/24/2007	8/22/2007
6/25/2007	8/23/2007
6/26/2007	8/24/2007
6/27/2007	8/25/2007
6/28/2007	8/26/2007
6/29/2007	8/27/2007
6/30/2007	8/28/2007

DATE OF HIRE	60TH DAY OF EMPLOYMENT
JULY	
7/1/2007	8/29/2007
7/2/2007	8/30/2007
7/3/2007	8/31/2007
7/4/2007	9/1/2007
7/5/2007	9/2/2007
7/6/2007	9/3/2007
7/7/2007	9/4/2007
7/8/2007	9/5/2007
7/9/2007	9/6/2007
7/10/2007	9/7/2007
7/11/2007	9/8/2007
7/12/2007	9/9/2007
7/13/2007	9/10/2007
7/14/2007	9/11/2007
7/15/2007	9/12/2007
7/16/2007	9/13/2007
7/17/2007	9/14/2007
7/18/2007	9/15/2007
7/19/2007	9/16/2007
7/20/2007	9/17/2007
7/21/2007	9/18/2007
7/22/2007	9/19/2007
7/23/2007	9/20/2007
7/24/2007	9/21/2007
7/25/2007	9/22/2007
7/26/2007	9/23/2007
7/27/2007	9/24/2007
7/28/2007	9/25/2007
7/29/2007	9/26/2007
7/30/2007	9/27/2007
7/31/2007	9/28/2007

DATE OF HIRE	60TH DAY OF EMPLOYMENT
AUGUST	
8/1/2007	9/29/2007
8/2/2007	9/30/2007
8/3/2007	10/1/2007
8/4/2007	10/2/2007
8/5/2007	10/3/2007
8/6/2007	10/4/2007
8/7/2007	10/5/2007
8/8/2007	10/6/2007
8/9/2007	10/7/2007
8/10/2007	10/8/2007
8/11/2007	10/9/2007
8/12/2007	10/10/2007
8/13/2007	10/11/2007
8/14/2007	10/12/2007
8/15/2007	10/13/2007
8/16/2007	10/14/2007
8/17/2007	10/15/2007
8/18/2007	10/16/2007
8/19/2007	10/17/2007
8/20/2007	10/18/2007
8/21/2007	10/19/2007
8/22/2007	10/20/2007
8/23/2007	10/21/2007
8/24/2007	10/22/2007
8/25/2007	10/23/2007
8/26/2007	10/24/2007
8/27/2007	10/25/2007
8/28/2007	10/26/2007
8/29/2007	10/27/2007
8/30/2007	10/28/2007
8/31/2007	10/29/2007

EMPLOYEE BENEFITS
DEADLINE DATES

DATE OF HIRE	60TH DAY OF EMPLOYMENT
SEPTEMBER	
9/1/2007	10/30/2007
9/2/2007	10/31/2007
9/3/2007	11/1/2007
9/4/2007	11/2/2007
9/5/2007	11/3/2007
9/6/2007	11/4/2007
9/7/2007	11/5/2007
9/8/2007	11/6/2007
9/9/2007	11/7/2007
9/10/2007	11/8/2007
9/11/2007	11/9/2007
9/12/2007	11/10/2007
9/13/2007	11/11/2007
9/14/2007	11/12/2007
9/15/2007	11/13/2007
9/16/2007	11/14/2007
9/17/2007	11/15/2007
9/18/2007	11/16/2007
9/19/2007	11/17/2007
9/20/2007	11/18/2007
9/21/2007	11/19/2007
9/22/2007	11/20/2007
9/23/2007	11/21/2007
9/24/2007	11/22/2007
9/25/2007	11/23/2007
9/26/2007	11/24/2007
9/27/2007	11/25/2007
9/28/2007	11/26/2007
9/29/2007	11/27/2007
9/30/2007	11/28/2007

DATE OF HIRE	60TH DAY OF EMPLOYMENT
OCTOBER	
10/1/2007	11/29/2007
10/2/2007	11/30/2007
10/3/2007	12/1/2007
10/4/2007	12/2/2007
10/5/2007	12/3/2007
10/6/2007	12/4/2007
10/7/2007	12/5/2007
10/8/2007	12/6/2007
10/9/2007	12/7/2007
10/10/2007	12/8/2007
10/11/2007	12/9/2007
10/12/2007	12/10/2007
10/13/2007	12/11/2007
10/14/2007	12/12/2007
10/15/2007	12/13/2007
10/16/2007	12/14/2007
10/17/2007	12/15/2007
10/18/2007	12/16/2007
10/19/2007	12/17/2007
10/20/2007	12/18/2007
10/21/2007	12/19/2007
10/22/2007	12/20/2007
10/23/2007	12/21/2007
10/24/2007	12/22/2007
10/25/2007	12/23/2007
10/26/2007	12/24/2007
10/27/2007	12/25/2007
10/28/2007	12/26/2007
10/29/2007	12/27/2007
10/30/2007	12/28/2007
10/31/2007	12/29/2007

DATE OF HIRE	60TH DAY OF EMPLOYMENT
NOVEMBER	
11/1/2007	12/30/2007
11/2/2007	12/31/2007
11/3/2007	1/1/2008
11/4/2007	1/2/2008
11/5/2007	1/3/2008
11/6/2007	1/4/2008
11/7/2007	1/5/2008
11/8/2007	1/6/2008
11/9/2007	1/7/2008
11/10/2007	1/8/2008
11/11/2007	1/9/2008
11/12/2007	1/10/2008
11/13/2007	1/11/2008
11/14/2007	1/12/2008
11/15/2007	1/13/2008
11/16/2007	1/14/2008
11/17/2007	1/15/2008
11/18/2007	1/16/2008
11/19/2007	1/17/2008
11/20/2007	1/18/2008
11/21/2007	1/19/2008
11/22/2007	1/20/2008
11/23/2007	1/21/2008
11/24/2007	1/22/2008
11/25/2007	1/23/2008
11/26/2007	1/24/2008
11/27/2007	1/25/2008
11/28/2007	1/26/2008
11/29/2007	1/27/2008
11/30/2007	1/28/2008

DATE OF HIRE	60TH DAY OF EMPLOYMENT
DECEMBER	
12/1/2007	1/29/2008
12/2/2007	1/30/2008
12/3/2007	1/31/2008
12/4/2007	2/1/2008
12/5/2007	2/2/2008
12/6/2007	2/3/2008
12/7/2007	2/4/2008
12/8/2007	2/5/2008
12/9/2007	2/6/2008
12/10/2007	2/7/2008
12/11/2007	2/8/2008
12/12/2007	2/9/2008
12/13/2007	2/10/2008
12/14/2007	2/11/2008
12/15/2007	2/12/2008
12/16/2007	2/13/2008
12/17/2007	2/14/2008
12/18/2007	2/15/2008
12/19/2007	2/16/2008
12/20/2007	2/17/2008
12/21/2007	2/18/2008
12/22/2007	2/19/2008
12/23/2007	2/20/2008
12/24/2007	2/21/2008
12/25/2007	2/22/2008
12/26/2007	2/23/2008
12/27/2007	2/24/2008
12/28/2007	2/25/2008
12/29/2007	2/26/2008
12/30/2007	2/27/2008
12/31/2007	2/28/2008

WHO'S WHO IN BENEFITS

Supervisor
Terry Kellogg 222-5872

Benefits Team Leaders
Sharon Boelcskevy 324-3432
Denise Childress 324-4172
Mary Hoffman 324-4915

Deferred Compensation/
Virginia College Savings Plan

- **HELP Desk** 324-4995
  - Mitch Falter, AIG-VALIC (Tuesday and Thursday)
  - Mark Lesyone or Gloria Moody ICMA (Monday and Wednesday)
  - Marjorie Allen, Nationwide Retirement Solutions (Friday)

- **Deferred Compensation contribution questions (all plans) and training programs**
  Donna Dowd 324-3374

Dental Insurance

- **Enrollment questions/concerns:**
  Val Carter 324-4708

- **Claims questions/concerns:**
  - **Delta Dental of Virginia**
    Customer Svc. 800-237-6060

Family/Medical Leave Benefits and Leave Without Pay Benefits
Sharon Boelcskevy 324-3432

Flexible Spending Accounts

- Dependent Care Assistance/
- Medical Spending Accounts
  Mary Hughes 324-4916

- **Claims questions/concerns:**
  - **Fringe Benefits Management Company**
    Customer Service 800-342-8017

Health Insurance

- **Enrollment questions/concerns:**
  - **BlueChoice POS**
  - **Blue Preferred PPO**
    Val Carter 324-4708
  - **CIGNA OAP**
  - **Kaiser**
    Mary Hughes 324-4916

- **Claims questions/concerns:**
  - **Blue Choice and Blue Preferred PPO**
    Betsi Fuhrman 324-3474
  - **CIGNA OAP**
    Customer Service 800-CIGNA24
  - **Kaiser Permanente**
    Member Services 301-468-6000

- **COBRA Continuation Coverage**
  Doug Sachs 324-3316

Long Term Care Insurance

- **Eligibility/Enrollment**
  Tram Nguyen 324-3437
  Mary Hoffman 324-4915
- **Enrollment Kits/Claims**
  - **AETNA**
    Customer Service 800-537-8521

Long Term Disability Insurance (LTD)

- **Eligibility / Enrollment / New Claims**
  Tram Nguyen 324-3437
  - **CIGNA**
    Claims Status 800-238-2125
    Evidence of Insurability Questions 800-352-0611

Life Insurance

- **Eligibility / Enrollment / Claims**
  Tram Nguyen 324-3437
  Evidence of Insurability Questions 800-872-2214

For questions regarding retirement benefits, contact the Retirement Administration Agency at 279-8200 / 800-333-1633

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DELTA DENTAL

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T.RowePrice
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Aetna®

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ICMA-RC
Building Retirement Security